BlueCross BlueShield of Texas

HealthSelect of Texas

CONSUMER DIRECTED HealthSelect

Participant Request for Transition of Care Benefits and Release of Information

Please complete this form if you are currently receiving medical care from a physician(s) that is not in the HealthSelect network and would like to apply to receive in-network benefits during a transitional time. In order to approve your request, it may be necessary for Blue Cross and Blue Shield of Texas (BCBSTX) to request medical information from your current physician(s). Transition of care benefits for covered services will be determined by BCBSTX.

Important ☞After submission of this form, a BCBSTX Personal Health Assistant will contact you within five business days on average. A formal, written, decision letter regarding your request for transition of care benefits will be mailed to you. If you have any questions regarding this form or transition of care benefits, contact a BCBSTX Personal Health Assistant at (800) 252-8039.

Retiree/Employee Name:_____ Date of Birth:_____

PATIENT INFORMATION

Name: _____ Date of Birth:_____ Relationship to Retiree/Employee:_____

Address: _____ City:_____ State:_____ ZIP:_____

Phone: Home:_____ Work:_____ Cell:_____

MEDICAL INFORMATION

What is the health condition, diagnosis or treatment Plan for which the patient is seeking transitional benefits? _____

Is the patient receiving care for a pregnancy? Yes ☐ No ☐ If Yes, what is the estimated due date? _____

Is there a surgery scheduled or recently done? Yes ☐ No ☐ If Yes, what is/was the date of the surgery? _____

Is the patient currently on a transplant list? Yes ☐ No ☐ If Yes, please provide a copy of the approval letter.

Does patient have a physician appointment scheduled? Yes ☐ No ☐ If Yes, please indicate the date of the patient's next appointment. _____

PHYSICIAN INFORMATION

Physician 1 Name	Address	Phone #	
Name of Facility (Hospital, DME, Group)		**Date of Last Visit**	**Date of Next Visit**
NOTE: IF YOU ARE SEEKING TRANSITION OF CARE SERVICES FROM ADDITIONAL PROVIDERS PLEASE INCLUDE THEM BELOW			
Physician 2 Name	**Address**	**Phone #**	
Name of Facility (Hospital, DME, Group)		**Date of Last Visit**	**Date of Next Visit**
Physician 3 Name	**Address**	**Phone #**	
Name of Facility (Hospital, DME, Group)		**Date of Last Visit**	**Date of Next Visit**

A clinical representative from BCBSTX may contact your physician(s) listed above to obtain medical records or additional medical information related to your request.

What is the best number to reach you? Home:_____ Work:_____

I hereby authorize the Blue Cross and Blue Shield of Texas Medical Director or designee to obtain any information and medical records from the above physician(s) / provider(s) in connection with making an informed decision regarding my request for Treatment in Progress (Transition of Care Benefits) under the HealthSelect plan. I understand that I am entitled to a copy of this Authorization Form.

Signed (Patient or Guardian):_____ Date:_____

Return form to:	**Fax: (972) 766-9601**	**Mailing Address: Blue Cross and Blue Shield of Texas** **4002 Loop 322** **Abilene, TX 79602**