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