BlueCross BlueShield of Texas

Request for Continued Access to Providers

Please complete this form if you are currently receiving ongoing medical care from providers that are not in-network under your new health plan or have recently terminated from the BCBS network. In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s).

Select request type (please check one): Transitioning of Care (New to Blue) ☐ Continuity of Care (Special Circumstances, Existing Accnts, switching from one Provider to another, Provider Groups/Facilities Terminating) ☐

Please Fill in Form:

Group Name: _____ Group Number: _____

Employee Name: _____ Member ID #: _____ Date of Birth: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Relation to Employee: _____

Address: _____ City: _____ State: _____ Zip Code: _____

MEDICAL / BEHAVIORAL HEALTH (Mental Health/Substance Use Disorder)

Diagnosis/Treatment Plan:

_____

_____

_____

_____

MEDICAL

PROVIDER INFORMATION

Name: _____

NPI ID #: _____

Phone #: _____

Fax #: _____

Address: _____

Date of last visit: _____ Next visit: _____

Please check as applicable:

☐ Pregnancy or undergoing course of treatment for pregnancy.
Estimated due date: _____

☐ Surgery scheduled or recently performed
Date of surgery: _____

☐ Scheduled for nonelective surgery.
Date of nonelective surgery: _____

☐ Including receipt of postoperative care.
Date of post-op care receipt: _____

☐ Transplant list
Please provide copy of approval letter

☐ Physician appointment scheduled
Date of appt: _____

☐ Undergoing a course of treatment for serious and complex condition.
Dates of Frequency and Duration: _____

☐ Undergoing institutional or inpatient care from the provider.
Dates Range of Inpatient Stay: _____

☐ Having been determined to be terminally Ill.
Date declared terminally ill: _____

Medical Instructions: Fax to: 1-866-739-4093 I Mail to:
Blue Cross Blue Shield of Texas P.O. Box 660044, Dallas, TX 75266-0044

BEHAVIORAL HEALTH

Procedure Code: _____

(Absence of a procedure code will not be a basis for denial)

PROVIDER INFORMATION

Name:

NPI ID #: _____

Phone #: _____

Fax #: _____

Address: _____

_____

Date of last visit: _____ Next visit: _____

Provider specialty (please check one)

☐ MD/DO (Medical Doctor/Doctor of Osteopathic Medicine)
☐ PHD (Doctor of Philosophy)
☐ LCSW (Licensed Clinical Social Worker)
☐ LPC/LCPC (Licensed Professional Counselor/Licensed Clinical Professional Counselor)
☐ LMFT (Licensed Marriage and Family Therapist)
☐ BCBA (Board Certified Behavior Analyst) Other

☐ **Instructions:**

Fax to: 1-877-361-7646
Attention: Transitional Care Request
Member Services phone: 1-800-528-7264

Phone: Home _____ Work _____ Cell _____

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 (Transitional Care benefits) under my new Health Plan. I understand that I am entitled to a copy of this Authorization Form.

Signed (Patient or Guardian): _____ Date: _____