



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.

Select request type (please check one): Transitioning of Care (New to Blue) [] Continuity of Care (Special Circumstances, Existing Acnts, switching from one Provider to another, ProviderGroups/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.
[] Surgery scheduled or recently performed
[] Scheduled for nonelective surgery.
[] Including receipt of postoperative care.
[] Transplant list
[] Physician appointment scheduled
[] Undergoing a course of treatment for serious and complex condition.
[] Undergoing institutional or inpatient care from the provider.
[] Having been determined to be 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

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.

Signed (Patient or Guardian): _____ Date: _____

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