



EDS Health Advocate Program Transitional Benefits/Release of Patient Information Form

THIS FORM SHOULD BE COMPLETED ONLY IF YOU ARE USING A NON-NETWORK PHYSICIAN

Employee Name:		Date of Birth:	
EDS Group Number:		ID#/SS#:	
PATIENT INFORMATION			
Patient Name:		Relationship:	
Address:		City:	
State:	Zip:	Date of Birth:	
Home Phone: ()		Work Phone: ()	
MEDICAL/BEHAVIORAL HEALTH INFORMATION			
What is your health condition? (Include diagnosis, if known, and check (✓) pertinent details below)			
_____ Pregnancy? If so, estimated due date?		Date:	
_____ Surgery currently scheduled? When?			
Type of surgery?			
_____ Home Health Services		Type:	
_____ Treatment or therapy in progress?			
_____ Currently on a transplant list? (If yes, please provide copy of approval letter)			
_____ Case manager (CM) from your previous health plan?		Plan:	
CM name:		Phone: ()	
_____ Any other insurance coverage?			Member ID:
Company Name:			
PROVIDER INFORMATION			
Physician:		Phone: ()	
Address:		Date of last visit:	
Facility:		Phone: ()	
PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION			
I hereby authorize Blue Cross and Blue Shield Medical Director to obtain any information and medical records from the above physician(s) necessary to make an informed decision concerning my request for Treatment in Progress (Transitional Care) benefits under the Medical Health Plan. I understand I am entitled to a copy of this Authorization Form.			
Date: _____ SIGNED (Patient or Guardian): _____ Relationship: _____			
RETURN THIS FORM BY THE FOLLOWING METHODS			
Medical Requests: By fax: 1-800-311-9983		Behavior Health Requests: By fax: 314-292-1191	
By mail: Blue Cross and Blue Shield of Texas Health Advocate Program P.O. Box 833874 Richardson, TX 75083-3874			

Thank you for your cooperation in completing the above information so that we may better assist you during this transition period.