

Transitional Benefits Form

THIS FORM SHOULD BE COMPLETED ONLY IF YOU ARE USING A NON-NETWORK PHYSICIAN OR WOULD LIKE TO RECEIVE A CALL FROM A BCBSTX CASE MANAGER TO DISCUSS COORDINATION OF CARE NEEDS FOR YOU OR A FAMILY MEMBER.

PATIENT INFORMATION

NAME: _____ ID#/SS#: _____

GROUP NAME/NUMBER: _____ LOCATION: _____

PATIENT NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: _____ HOME PHONE: (____) _____

:

WORK PHONE: (____) _____

PATIENT ADDRESS: _____

MEDICAL /BEHAVIORAL HEALTH INFORMATION

PREGNANCY Estimated Due Date: _____

SURGERY CURRENTLY SCHEDULED: _____ DATE: _____

TYPE OF SURGERY: _____

HOME HEALTH SERVICES: _____

TREATMENT OR THERAPY IN PROGRESS: _____

TYPE OF TREATMENT/THERAPY: _____

WOULD YOU LIKE TO TALK WITH A CASE MANAGER REGARDING THE COORDINATION OF HEALTH CARE SERVICES FOR YOU OR A FAMILY MEMBER?

YES NAME: _____ PHONE: (____) _____

NO

DO YOU HAVE OTHER INSURANCE COVERAGE?

YES NAME: _____ MEMBER ID: _____

NO

PROVIDER INFORMATION

PROVIDER: _____ PROVIDER PHONE: (____) _____

FACILITY: _____ FACILITY PHONE: (____) _____

THANK YOU FOR YOUR COOPERATION IN COMPLETING THE ABOVE INFORMATION SO THAT WE MAY BETTER ASSIST YOU DURING THIS TRANSITION PERIOD.

PLEASE MAIL OR FAX THIS FORM TO:

Blue Cross and Blue Shield of Texas
Utilization Management
C/O Scottie Bradshaw, RN – Transitional Benefits
PO Box 833874
Richardson, TX 75083-3874
OR FAX : 1-866-221-3607

OR E-MAIL : Scottie_Bradshaw@HCSCTX.COM