



Group Number 085000

www.trs.state.tx.us/trs-activecare

Toll-Free Customer Service 1-866-355-5999

This form should be completed only if you are using a non-network physician.

District/Employer Name			
Employee Last Name	First Name	Date of Birth	Employee Social Security Number

SECTION 1 – PATIENT INFORMATION

Patient's Last Name	First Name	Middle Initial
Patient's Social Security Number	Date of Birth <small>MM DD YYYY</small>	Relationship to Employee
Patient's Place of Residence/Address	City	State ZIP Code
Work Phone ()	Ext.	Home Phone ()

SECTION 2 – MEDICAL/BEHAVIORAL HEALTH INFORMATION

What is the health condition for which you are seeking transitional benefits? _____
 (include diagnosis, if known and check (✓) pertinent details below) Diagnosis _____

Pregnancy Estimated Due Date _____

Surgery Scheduled or Recently Done Type of Surgery _____ Date _____

Home Health Services Type _____

Treatment or Therapy in Progress Type _____

Currently on a Transplant List (if checked, please attach copy of approval letter)

Do you have a case manager from your previous health plan? _____
 Yes No Case Manager's Name _____ Previous Health Plan Name _____ Phone () _____

Do you have other insurance coverage? _____
 Yes No Company Name _____ Member ID _____

SECTION 3 – PROVIDER INFORMATION

Provider Name	Provider Phone ()				
Address	City	State	ZIP Code	Date Last Seen	Next Visit On
Facility Name	Facility Phone ()				

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

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 provider(s) in connection with making an informed decision regarding my request for treatment in progress (transitional care benefits) under the medical health plan. I understand that I am entitled to a copy of this authorization form.

Date: _____ Signature (Patient or Guardian): _____ Relationship: _____

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

Medical, Surgical or Pregnancy Requests

Fax To: 1-800-311-9983

Or mail to: Blue Cross and Blue Shield of Texas
Utilization Management
c/o Scottie Bradshaw, RN – Transitional Benefits
P.O. Box 833874
Richardson, TX 75083-3784

Behavioral Health Requests

Fax to: 1-888-656-4942

Attn: Eddie Guerrero or Raquel Perry