



Group Number 085000 www.trs.state.tx.us/trs-activecare Toll-Free Customer Service 1.866.355.5999

This Transitional Care Request form should be completed and submitted only if you are using a non-network physician.

District/Entity/Employer Name		Employee Social Security Number			
Employee Last Name	First Name	Middle Initial	Employee Date of Birth		
			MM	DD	YYYY

SECTION 1 — PATIENT INFORMATION

Patient's Last Name	First Name	Middle Initial
Patient's Social Security Number	Date of Birth	Relationship to Employee
	MM DD YYYY	
Patient's Place of Residence/Address	City	State Zip
Work Phone ()	Home Phone ()	

SECTION 2 — MEDICAL/BEHAVIORAL HEALTH INFORMATION

What is your HEALTH CONDITION? (Include diagnosis, if known, and check (✓) pertinent details below)

<input type="checkbox"/> Pregnancy	Estimated Due Date	
<input type="checkbox"/> Surgery Currently Scheduled	Type of Surgery Date	
<input type="checkbox"/> Home Health Services	Type of Treatment	
<input type="checkbox"/> Treatment or Therapy in Progress	Type of Treatment or Therapy	
<input type="checkbox"/> Currently on a transplant list? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide copy of approval letter)		
Previous Health Plan Name	Do you have a Case Manager from your previous health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Case Manager's Name	Phone ()
Do you have other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance Name	Member ID

SECTION 3 — PROVIDER INFORMATION

Physician Name	Physician Phone ()
Facility Name	Facility Phone ()
Address	Phone Date of Last Visit

SECTION 4 — PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Blue Cross and Blue Shield of Texas 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.

Signed (Patient or Guardian)	Relationship	Date
------------------------------	--------------	------

SECTION 5 — RETURN THIS FORM BY THE FOLLOWING METHODS

<p>Medical Requests Fax to: 1-866-221-3607 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 75083-3874</p>	<p>Behavioral Health Requests Fax to: 1-800-358-2946</p>
--	---