



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? \_\_\_\_\_ Previous Health Plan Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Yes  No Case Manager's Name \_\_\_\_\_

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

**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: 1-866-221-3607

**Behavioral Health Requests** Fax to: 1-877-361-7646

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