# TRANSITIONAL BENEFITS / RELEASE OF PATIENT INFORMATION FORM

BlueCross BlueShield of Texas

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

BCBSTX Route to UMCAT - 1200 for processing

| | |
|---|---|
| EMPLOYEE NAME: | DATE OF BIRTH: |
| GROUP NAME/ NUMBER: | ID#/SS#: |

**PATIENT INFORMATION**

| | |
|---|---|
| **PATIENT NAME:** | RELATIONSHIP TO EMPLOYEE: |
| ADDRESS: | CITY: |
| STATE: ZIP: | DATE OF BIRTH: |
| HOME PHONE: ( ) | WORK PHONE: ( ) Ext: |

**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:**

**Additional information:**

☐ **PREGNANCY?** If yes, what is your e**stimated due date**?

☐ **SURGERY** SCHEDULED **or** RECENTLY DONE? **DATE:**

**TYPE OF SURGERY?**

☐ HOME HEALTH SERVICES? **TYPE:**

☐ TREATMENT OR **THERAPY** IN PROGRESS? **TYPE:**

☐ CURRENTLY ON A **TRANSPLANT LIST?** ( IF YES, PLEASE ATTACH COPY OF APPROVAL LETTER **)**

☐ CASE MANAGER(CM) FROM YOUR PREVIOUS HEALTH PLAN? **PLAN:**

CM NAME: **PHONE:**

☐ ANY OTHER INSURANCE COVERAGE? **COMPANY NAME:** **ID #:**

**PROVIDER INFORMATION**

| | |
|---|---|
| **PROVIDER** (MD, DO, etc): | PHONE: ( ) |
| ADDRESS: | DATE LAST SEEN: |
| CITY/STATE/ZIP: | NEXT VISIT ON: |
| **FACILITY** (Hosp., DME, group): | 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 I am entitled to a copy of this Authorization Form.

| | |
|---|---|
| **DATE:** | **SIGNED** (Patient or Guardian): |
| | **RELATIONSHIP:** |

**RETURN THIS FORM BY THE FOLLOWING METHODS**

**Behavioral Health Requests ONLY - - By Fax: 877-301-7079**

**MEDICAL, SURGICAL, OR PREGNANCY REQUESTS:**

**By FAX to:** **1 (866) 221-3607**

**or**

**By 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

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



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