

BlueCross BlueShield of Texas

Request for Continued Access to Providers

Please complete this form if you are currently receiving ongoing medical care from providers that are not in-network under your new health plan or have recently terminated from the BCBS network. In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s).

	er(s). ling of Care (New to Blue) Continuity of Care (Special Circumstances, Existing ider Groups/Facilities Terminating) Behavioral Health (Reports, Referral Cases
Please Fill in Form:	
Group Name: ————————————————————————————————————	Group Number:
Employee Name:	Member ID #:Date of Birth:
PATIENT INFORMATION	
Name:D	Pate of Birth:Relation to Employee:
	State:Zip Code:
	ORAL HEALTH (Mental Health/Substance Use Disorder)
	JRAL HEALTH (Mental Health/Substance Use Disorder)
Diagnosis/Treatment Plan:	
MEDICAL	BEHAVIORAL HEALTH
PROVIDER INFORMATION	Procedure Code:
Maria	
Name:	
NPI ID #:	(Absence of a procedure code will not be a basis for denial)
Phone #:	
Fax #:	
Address:	
Date of last visit:Next visit:	NPI ID#:
Please check as applicable:	Phone #:
• •	Fax #: ———————————————————————————————————
☐ Pregnancy or undergoing course of treatment for p	
Estimated due date:	
☐ Surgery scheduled or recently performed	Date of last visit:Next visit:
Date of surgery:	
- ·	Provider specialty (please check one)
Date of nonelective surgery:	 ☐MD/DO (Medical Doctor/Doctor of Osteopathic Medicine)
Date of post-op care receipt:	□PHD (Doctor of Philosophy)
☐ Transplant list	LCSW (Licensed Clinical Social Worker)
Please provide copy of approval letter	LPCLCPC (Licensed Professional Counselor/Licensed Clinical Professional
Physician appointment scheduled	Counselor)
Date of appt:	LMFT (Licensed Marriage and Family Therapist)
☐ Undergoing a course of treatment for serious and comp	olex condition. □BCBA (Board Certified Behavior Analyst)
Dates of Frequency and Duration:	Other
☐ Undergoing institutional or inpatient care from the prov	vider. Instructions:
Dates Range of Inpatient Stay:	Fax to: 1-877-361-7646
Having been determined to be terminally III. Date declared terminally ill:	Attention: Transitional Care Request
Date decidied terminally III.	Member Services phone: 1-800-528-7264
Medical Instructions: Fax to: 1-866-739-4093 Mail to: Blue Cross Blue Shield of Texas P.O. Box 660044, Dallas, T.	X 75266-0044
Phone: HomeV	VorkCell
	dical Director or designee to obtain any information and medical records from the above
·	ed decision regarding my request for Treatment in Progress (Transitional Care benefits) under my
new Health Plan. Lunderstand that Lam entitled to a copy of	this Authorization Form