

Transition of Care

What are Transition-of-Care Benefits?

Transition-of-care benefits let you continue using your current provider on an in-network basis for a limited time, even if your provider isn't in the Blue Cross Blue Shield of Texas (BCBSTX) network.

Covered Treatments

You should look into transition-of-care benefits if you or your family member is receiving care for covered treatments and your current physician won't be part of the BCBSTX network. Covered treatments may include (but are not limited to) the following:

- Existing pregnancy in the third trimester or high risk pregnancy (extends through the postpartum visit)
- Scheduled surgeries
- Cancer
- A chronic or degenerative, life threatening or disabling disease or condition
- A chronic psychiatric condition
- Post-operative care

Length of Treatment

Transition-of-care benefits limited to a maximum of ninety (90) days from December 31, 2013. If you are in the third trimester of pregnancy, transition-of-care benefits extend through the post-partum visit.

It's important to call BCBSTX at 1-877-219-4303 to see if your condition will quality for transition-of-care benefits. If the treatment you are receiving qualifies, complete the attached Transitional Benefits form and return it to BCBSTX at the address on the form.

TRANSITIONAL BENEFITS / RELEASE OF PATIENT INFORMATION FORM



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#:	
onto on the mile manufacture.		IFORMATION
PATIENT NAME:	RELATIC	ONSHIP TO EMPLOYEE:
ADDRESS:	CITY:	
STATE: ZIP:	DATE OF	BIRTH:
HOME PHONE: ()	WORK P	
MEDIC	AL/BEHAVIORAL	L HEALTH INFORMATION
What is the HEALTH CONDITION for which you are s	eeking Transitiona	Il Benefits?
(Include diagnosis, if known, and check ($\sqrt{\ }$) pertinent details be	elow)	Diagnosis:
Additional information:		
□ PREGNANCY? If yes, what is your estimated du	e date?	
□ SURGERY SCHEDULED OF RECENTLY DONE? DAT		
	· — · — — — — — — — — — — — — — — — — —	
TYPE OF SURGERY?		
☐ HOME HEALTH SERVICES? TYI	PE:	
☐ TREATMENT OR THERAPY IN PROGRESS? TYI	PE:	
☐ CURRENTLY ON A TRANSPLANT LIST? (IF YES, F	PLEASE ATTACH CO	PY OF APPROVAL LETTER)
☐ CASE MANAGER(CM) FROM YOUR PREVIOUS HEALTH	I PLAN?	PLAN:
CM NAME:		PHONE:
☐ ANY OTHER INSURANCE COVERAGE? COMPANY NAM	IE:	ID #:
	PROVIDER I	NFORMATION
PROVIDER (MD, DO, etc):		()
ADDRESS:		ST SEEN:
CITY/STATE/ZIP:		SIT ON:
FACILITY (Hosp., DME, group):		()
		OR RELEASE OF INFORMATION
I hereby authorize the Blue Cross and Blue Shield of T from the above provider(s) in connection with making (Transitional Care benefits)under the Medical Health F DATE: SIGNED (Patient or Guardian):	an informed decis	
RELATIONSHIP:		
	THIS FORM BY T	HE FOLLOWING METHODS
Behavioral Health Requests ONLY By Fa		
MEDICAL, SURGICAL, OR PREGNANCY RE		
		Plus Cross and Plus Shield of Toyon
By FAX to: <u>or</u>	By MAIL to:	Blue Cross and Blue Shield of Texas
1 (866) 221-3607		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.