

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

District/Employer Name			
Employee Last Name	First Name	Middle Initial	Employee Social Security Number

**SECTION 1 — PATIENT INFORMATION**

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

**SECTION 2— MEDICAL INFORMATION**

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

**SECTION 3 —PROVIDER INFORMATION**

Physician Name	Physician Phone
Facility Name	Facility Phone

**Thank you for your cooperation in completing the above information so that we may better assist you during this transition period.**

**Mail To: Blue Cross and Blue Shield of Texas    or    Fax To: 1-800-311-9983**  
**Utilization Management**  
**2400 Lakeside Dr., 5th Floor**  
**Richardson, TX 75082**