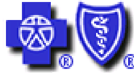

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

P.O. Box 805107
Chicago, IL 60680-4112

Member Request for Transitional Care Benefits and Release of Information

Please complete this form if you are currently receiving medical care from providers that are not listed in your provider directory and would like assistance in coordinating your medical care with the new medical plan. It may be necessary to request medical information from your current provider. Your signature at the bottom of this form allows Blue Cross and Blue Shield of Illinois to request this information.

Important ☞ Transitional Care Benefits must be discussed with a Case Management Specialist if your group contract is already in effect. Please call the Pre-certification telephone number indicated on the back of your Identification Card.

Group #: ____________________ **Employer Name:** ____________________

Employee Name: ____________________ SS#: ____________________

Address: ____________________

Telephone# (Home): ____________________ Work: ____________________

Patient Name: ____________________ Relationship to Employee: ____________________

Have you chosen a Primary Care Physician (PCP) or PPO Provider? Yes ☐ No ☐

If yes, Name: ____________________ Address: ____________________

Blue*Choice* (POS) - Your Primary Care Physician (PCP) must coordinate your medical care to receive the highest contract benefit level.

Participating Provider Option (PPO) - You must chose providers in the PPO Network to receive the highest contract benefit level for your medical care.

What is your health condition? ____________________

Please list any medical services you are currently receiving outside of the Plan. This would include, but is not limited to: Home Health Care, Physical Therapy, Occupational Therapy, Inpatient Hospital Admission, Outpatient Surgery, Post-Operative Follow Up Care, Obstetrical Care, Kidney Dialysis, Cardiac Rehabilitation, etc.

Are you currently on a Transplant list? Yes ☐ No ☐ (If yes, please provide a copy of the approval letter).

Current physician or provider: (Please print or type)

Name	Phone #	Type of Care	Date of Last Visit
Name	Phone #	Type of Care	Date of Last Visit
Name	Phone #	Type of Care	Date of Last Visit

A Utilization Management representative may contact you to obtain medical records for clinical review.

What phone number shall we call? Home ____________________ Work ____________________

I hereby authorize BCBSI Medical Director to obtain any information and medical records from the above physician(s) necessary to make an informed decision concerning 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.

Signed: (Patient or Guardian) ____________________ Date: ____________________