HealthSelect of Texas® CONSUMER DIRECTED HealthSelect®

BlueCross BlueShield of Texas

Participant Request for Transition of Care Benefits and Release of Information

Please complete this form if you are currently receiving care from a mental health provider(s) that is not in the HealthSelect network and would like to apply to receive in-network benefits during a transitional time. In order to approve your request, it may be necessary for Blue Cross and Blue Shield of Texas (BCBSTX) to request medical information from your current physician(s). Transition of care benefits for covered services will be determined by BCBSTX.

Important ☞ After submission of this form, a BCBSTX Personal Health Assistant will contact you within five business days. A formal, written decision letter regarding your request for transition of care benefits will be mailed to you. If you have any questions regarding this form or transition of care benefits, contact a BCBSTX Personal Health Assistant toll-free at (800) 252-8039, Monday-Friday 7 a.m. - 7 p.m. and Saturday 7 a.m. - 3 p.m. CT.

Employee/Retiree Name:		Date of Birth:
Group Number:	Subscriber ID:	
Phone Home:	Work:	Cell:

PATIENT INFORMATION

Name:	Date of Birth:	Relationship to Employee/Retiree:
Address:		
City:	State:	Zip:

DIAGNOSIS/TREATMENT PLAN

What is the mental health condition, diagnosis or treatment plan for which the patient is seeking transitional benefits?
Expected completion date for this plan of care?
Does the patient currently have an appointment scheduled? If yes, indicate the date of the patient's next appointment?

PROVIDER INFORMATION

PROVIDER NAME		LISCENSURE TYPE
NPI #	**PHONE**	**FAX**
ADDRESS:		

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NPI #	**PHONE**	**FAX**
ADDRESS:		

A clinical representative from BCBSTX may contact your provider(s) listed above to obtain medical records or additional medical information related to your request.

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 physician(s) / provider(s) in connection with making an informed decision regarding my request for Treatment in Progress (Transition of Care Benefits) under the HealthSelect plan. I understand that I am entitled to a copy of this Authorization Form.

Signed (Patient or Guardian):		Date:
Return form to:	Fax: (972) 766-9601	Mailing Address: Blue Cross and Blue Shield of Texas 4002 Loop 322 Abilene, TX 79602

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