Transitional Care Request form

Blue Cross Blue Shield of Michigan

Complete one form for each physician/treatment plan for which you are requesting Transitional Care consideration.

To be completed by member:

Effective date of BCBSM coverage: ______/______/______ Today's date: ______/______/______

Employer:____

Subscriber's name:____

Contract number:______________________________ Date of birth: ______/______/______

Address:_____________________________________City:______________________

State:______________ Zip:_______________ Phone:____________________ ☐Cell ☐ Work ☐ Home

Patient's name:______________________________ Relationship to subscriber:________________

Patient's date of birth: ______/______/______ Phone:_____________________ ☐Cell ☐ Work ☐Home

Reason for requesting continued treatment by non-network provider:___________________________

____

____

To be completed by treating physician:

Provider's name:____

Is provider: ☐ *participating* with BCBS or ☐ *non-participating*

Address:____City:___________________

State:________________ Zip:_____________ Phone:___________________ alt or ext: __________

Provider tax ID:_____________________________ NPI:_______________________________

Description of condition and treatment:_______________________________________

____

____

____

Proc code(s):_________________________ Dx code(s):_________________________

Expected duration of acute/current treatment: ____________________________________

Signature:____

Please return form to BCBSM Member Service. Call Customer Service at the number on the back of your ID card for fax number or specific mailing instructions.

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.