



Request for Continued Access to Providers for Ongoing Care

Please complete this form if you have a **prior authorization (PA) approval from your previous health plan or you are seeing an out-of-network Medicare-contracted provider**. It may be necessary to request medical information from your current provider(s) to complete this form.

Select request type (please check one):

- ☐ Transitioning of Care (New to Medicare Advantage)
- ☐ Continuity of Care (Request to continue care with a current provider if coverage or network is changing)

MEMBER INFORMATION

*Name: _____

*Date of Birth: _____

*Subscriber ID: _____

*Phone Number: _____

MEDICAL HEALTH PROVIDER

*Name: _____

*Provider Specialty: _____

*NPI ID #: _____

*Phone #: _____

*Fax #: _____

*Address: _____

*Do you have approved PA?
☐ Yes ☐ No

*Dates Approved: _____

*What Services? _____

*CPT Codes: _____

*Diagnosis Codes: _____

BEHAVIORAL HEALTH PROVIDER

*Name: _____

*Provider Specialty: _____

*NPI ID #: _____

*Phone #: _____

*Fax #: _____

*Address: _____

*Do you have approved PA?
☐ Yes ☐ No

*Dates Approved: _____

*What Services? _____

*CPT Codes: _____

*Diagnosis Codes: _____

Please check as applicable:

- ☐ Surgery scheduled or recently performed
Date of surgery: _____
- ☐ Receipt of postoperative care
Date of post-op care receipt: _____
- ☐ Transplant list:
Please provide copy of approval letter
- ☐ Physician appointment scheduled
Date of appt: _____

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|---|
| <input type="checkbox"/> Undergoing a course of treatment for serious and complex condition Dates of Treatment and Duration: |
| <input type="checkbox"/> Undergoing institutional or inpatient care from the provider Dates Range of Inpatient Stay: |
| <input type="checkbox"/> Having been determined to be terminally ill Date declared terminally ill: |
| <input type="checkbox"/> Pregnancy or undergoing course of treatment for pregnancy Estimated due date: |

*Required information – Form cannot be processed without required information

Signed (Patient or Guardian):_____ Date:_____

I hereby authorize the BCGMA 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 (Transitional Care benefits) under my new Health Plan. I understand that I am entitled to a copy of this Authorization Form.

Instructions: Fax or Mail
Attention: Transition of Care Request
Fax: 855-874-4711
Mail: P. O. Box 660964
Dallas, TX 75266-0694
Customer Service Phone: Call number on the back
of card of your card

HMO plan in New Mexico, HMO and HMO-POS plans in Illinois, and PPO plans in Illinois, Montana, and New Mexico are provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan in Illinois provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HMO Special Needs Plan and PPO Special Needs Plan in New Mexico provided by HCSC. HMO, PPO, and Dual Care HMO Special Needs plans in Texas provided by HCSC Insurance Services Company (HISC). PPO plan in New Mexico provided by HISC. HMO and PPO plans in Texas provided by GHS Insurance Company (GHSIC). All HMO and PPO employer/union group plans provided by HCSC. HMO plan in Oklahoma provided by GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (BlueLincs). HMO Special Needs Plan and PPO plans in Oklahoma provided by GHS Insurance Company (GHSIC). HCSC, ILBCBSIC, HISC, GHSIC, and BlueLincs are Independent Licensees of the Blue Cross and Blue Shield Association. ILBCBSIC, GHSIC and BlueLincs are Medicare Advantage organizations with a Medicare contract. HCSC is a Medicare Advantage organization with a Medicare contract and a contract with the New Mexico Medicaid program. GHSIC is a Medicare Advantage organization with a Medicare contract and a contract with the Oklahoma Medicaid program. HISC is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in these plans depends on contract renewal.