Blue Cross Group Medicare Advantage℠

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:

☐ Undergoing a course of treatment for serious and complex condition Dates of Treatment and Duration:
☐ Undergoing institutional or inpatient care from the provider Dates Range of Inpatient Stay:
☐ Having been determined to be terminally Ill Date declared terminally ill:
☐ 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