

Application for Transition of Care



Insured member:

Last Name	First Name	Social Security Number	Policy Number

Member needing transition assistance:

Last Name	First Name	Date of Birth	Relationship to Employee
Street	City	State	Zip Code
Phone number			

SECTION I – PLEASE PRINT

If you or a covered dependant are currently under the care of a non-network physician you may be eligible for transition of benefits. To apply, please answer questions 1 –7. You should send the completed application to Regence BlueCross BlueShield of Oregon, prior to the effective date of coverage.

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|----|---|------------------------------|-----------------------------|
| 1. | Is the member currently pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Is the member currently undergoing treatment for cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Is the member undergoing treatment for a fracture? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Has the member been hospitalized within the last six weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Has the member had surgery within the last six weeks? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. | Does the member have an appointment with the physician prior to the effective date, or within 30 days thereafter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. | Is the member being considered for organ transplant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Is Regence BlueCross BlueShield of Oregon the primary carrier for the member? Yes No

Is the member covered by Medicare or Medicaid? Yes No

List all physicians involved in the case:

Name	Specialty	Phone	Next Scheduled Appointment
Name	Specialty	Phone	Next Scheduled Appointment

SECTION II – PLEASE PRINT

If you are currently receiving case management services or are participating in a program for a chronic health condition, or have recently obtained preauthorization for medical services or equipment, please answer questions 8 – 11.

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|-----|---|------------------------------|-----------------------------|
| 8. | Is the member being case managed with the current carrier? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. | Has the member recently received a preauthorization for medical services or equipment from the current carrier? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. | Is the member currently undergoing treatment for diabetes, heart disease or asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. | If the answer to question #1 is yes, is she enrolled in a prenatal support program provided by the current carrier? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Insert comments regarding the above answers, if necessary:

Authorization to Release Records:

I authorize all physicians and other medical professionals or institutions to provide Regence BlueCross BlueShield of Oregon information concerning medical care, advice, treatment or supplies for the member named above. This information will be used to determine the member's eligibility for transition benefits when the member's benefits go into effect.

Member's Signature/Parent or Guardian's Signature if member is a minor	Date

Please send completed form to: Regence BlueCross BlueShield of Oregon, PO Box 1271, M/S E9A, Portland, OR 97207-1271 or FAX: 503-525-6595