BlueCross BlueShield of Illinois

Request for Continued Access to Providers

Please complete this form if you are currently receiving ongoing medical care from providers that are not in-network under your new health plan or have recently terminated from the Blue Cross and Blue Shield of Illinois network. In certain circumstances, the health plan may authorize the member to continue receiving medical care from an out-of-network provider at the in-network level of benefit for covered services. It may be necessary to request medical information from your current provider(s). Please print legibly in black ink.

SELECT REQUEST TYPE (PLEASE CHECK ONE):

☐ TRANSITIONING OF CARE (NEW TO BCBSIL)

☐ CONTINUITY OF CARE (SPECIAL CIRCUMSTANCES, EXISTING ACCOUNTS, SWITCHING FROM ONE PROVIDER TO ANOTHER, PROVIDER GROUPS/FACILITIES TERMINATING)

GROUP NAME	GROUP NUMBER	
EMPLOYEE NAME	MEMBER ID	DATE OF BIRTH

PATIENT INFORMATION

NAME		DATE OF BIRTH	RELATION TO EMPLOYEE
ADDRESS	CITY	STATE	ZIP CODE

MEDICAL

DIAGNOSIS/TREATMENT PLAN

MEDICAL PROVIDER INFORMATION

NAME	NPI ID #
PHONE #	FAX #
ADDRESS	
DATE OF LAST VISIT	NEXT VISIT

PLEASE CHECK AS APPLICABLE

☐ PREGNANCY OR UNDERGOING COURSE OF TREATMENT FOR PREGNANCY	ESTIMATED DUE DATE
☐ SURGERY SCHEDULED OR RECENTLY PERFORMED	DATE OF SURGERY
☐ SCHEDULED FOR NONELECTIVE SURGERY	DATE OF NONELECTIVE SURGERY
☐ INCLUDING 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 FREQUENCY 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

*Certain members may be eligible for continuation of care for a condition or disease that requires repeated services, pursuant to a treatment plan, because of the potential for changes in the therapeutic regimen or potential for a recurrence of symptoms.

BEHAVIORAL HEALTH (MENTAL HEALTH/SUBSTANCE USE DISORDER)

PROCEDURE CODE (ABSENCE OF A PROCEDURE CODE WILL NOT BE A BASIS FOR DENIAL)

PROVIDER INFORMATION

NAME	NPI ID #
PHONE #	FAX #
ADDRESS	
DATE OF LAST VISIT	NEXT VISIT

PROVIDER SPECIALTY (PLEASE CHECK ONE)

☐ MD/DO (MEDICAL DOCTOR/DOCTOR OF OSTEOPATHIC MEDICINE)
☐ PHD (DOCTOR OF PHILOSOPHY)
☐ LCSW (LICENSED CLINICAL SOCIAL WORKER)
☐ LPC/LCPC (LICENSED PROFESSIONAL COUNSELOR/LICENSED CLINICAL PROFESSIONAL COUNSELOR)
☐ LMFT (LICENSED MARRIAGE AND FAMILY THERAPIST)
☐ BCBA (BOARD CERTIFIED BEHAVIOR ANALYST) OTHER

MEDICAL INSTRUCTIONS

Fax to: 855-346-2021
Mail to: Blue Cross and Blue Shield of Illinois
PO BOX 660603
Dallas, TX 75266-0603

BEHAVIORAL HEALTH INSTRUCTIONS

Fax to: 877-361-7656
Attention: Transitional Care Request
Mail to: Blue Cross and Blue Shield of Illinois
PO BOX 660603
Dallas, TX 75266-0603

I hereby authorize the Blue Cross and Blue Shield of Illinois 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.

PRIMARY PHONE #	SECONDARY PHONE #
SIGNED (PATIENT OR GUARDIAN)	DATE