TRANSITION OF CARE REQUEST FORM

Anthem
And Its Affiliated HMOs

Mail to:
Anthem Blue Cross and Blue Shield
Attn: Medical Management
Mail Drop VA44A
P.O. Box 27401
Richmond, VA 23279

Fax to:
Medical Management
(804) 354-2578

TRANSITION OF CARE REQUEST (Please provide the following information)

Employee Name: _____ ID#: _____
Last First M.I.

Employee Home Address: _____

_____ _____ _____
City State Zip Code

Patient Name: _____ Relationship to employee: _____
Last First M.I.

Home Phone: ( ) _____ Work Phone: ( ) _____ Gender: ☐ Male ☐ Female Date of Birth: _____

Current Insurance Carrier: _____ Employer Name: _____

New Health Plan: ☐ HMO ☐ PPO ☐ POS ☐ Other: _____ Effective Date: _____
(Please Specify)

CURRENT MEDICAL INFORMATION

Surgery

☐ Inpatient ☐ Outpatient
Procedure: _____ Date Scheduled: _____

Hospital: _____ Phone: ( ) _____

Surgeon: _____ Office Phone: ( ) _____

Maternity

☐ Inpatient ☐ Outpatient

Obstetrician: _____ Office Phone: ( ) _____

Hospital: _____ Phone: ( ) _____

Expected Delivery Date: _____

Medical

☐ Inpatient ☐ Outpatient

Diagnosis: _____ Date Treatment Began: _____

Current Treatment Plan: _____

Treating Physician: _____ Office Phone: ( ) _____

RELEASE OF PATIENT INFORMATION

I hereby authorize all physician(s), hospital(s), other health care providers, health care agencies, health maintenance organizations and/or insurance companies to release any medical information to Anthem Blue Cross and Blue Shield about myself or eligible dependents.

Patient Signature: _____ Date Signed: _____

Employee Signature: _____ Date Signed: _____