

TRANSITION OF CARE REQUEST FORM



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: _____