



**of Tennessee**

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# PPO In Network Benefit Request Form (Patient Initiated Prior to Care)

-- Confidential --

Patient Name		Patient Date of Birth	Patient ID Number
Patient Street Address			
City	State	ZIP Code	County
Requested Provider's Name		Specialty	
Provider Street Address		Provider PIN# or Tax ID #	
City	State	ZIP Code	County
Beginning Date of Service	Ending Date of Service	No. of Visits Requested	

## Reason For Request

*(To Be Completed By Patient)*

**You may visit our Web site at [www.bcbst.com](http://www.bcbst.com) to obtain participating provider information.**

### Network Availability Issue Request

- Participating network provider not available       Patient Preference

### Transitional/Continuity of Care Request

- Maternity Related (*Patient in second or third trimester*)      Expected Delivery Date: \_\_\_\_\_
- Practitioner/Facility termed from network during treatment (*Provider must complete the information below*)
- Patient's network changed during treatment (*Provider must complete the information below*)
- Complex medical and/or behavioral health conditions (*Provider must complete the information below*)

Please include any additional comments you would like considered on your request: \_\_\_\_\_

**Patient Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

***This form must be signed by the patient in order to be processed. Incomplete requests will be returned.***

## Clinical Information to Support Transitional/Continuity of Care Request

*(To Be Completed By Provider)*

**Note to Provider:** *If your request is approved, your signature below indicates that you agree to accept reimbursement of maximum allowable charges as payment in full and will bill patient only for any applicable copay, coinsurance and/or deductible.*

Symptoms and Diagnosis: \_\_\_\_\_

Specify length of time you have treated the patient: \_\_\_\_\_

State clinical reasons why services cannot be rendered by a participating network provider: \_\_\_\_\_

**Provider Signature: X** \_\_\_\_\_ **Date:** \_\_\_\_\_

***This request is not valid until approved by BlueCross BlueShield of Tennessee.  
Please contact customer service at 1-800-565-9140 to confirm that your request has been approved.  
Care rendered without prior approval will be subject to out-of-network benefits.***

**Please return completed form to: BlueCross BlueShield of Tennessee, 1 Cameron Hill Circle, STE 0002, Chattanooga, Tennessee 37402-0002**