of Tennessee
bcbst.com

Network P&S PPO In Network Benefit Facility Request Form (Patient Initiated BEFORE Care)

-- Private --

Patient Name ______________________ Patient ID Number ______________ Patient Date of Birth ____________

Note to Member: In network benefits are paid at the maximum allowable charge set forth in your network. If your facility does not agree to accept this reimbursement amount, you may be billed for the difference.

Patient Street Address ____

City ______________________ State ______ ZIP Code ________ County ____________

Requested Facility's Name ____

Facility Street Address ______________________ Facility PIN# or Tax ID # ______________

City ______________________ State ______ ZIP Code ________ County ____________

Beginning Date of Service ______________ No. of Visits Requested ______________ Ending Date of Service ______________

Reason For Request

(To Be Filled Out By Patient)

*You may visit our website at **www.bcbst.com** to get participating facility facts.*

Network Availability Issue Request

- ❑ There are not any network Doctors/Hospitals available in my area
- ❑ I am new to this network *(and my Doctor/Hospital does not participate in this network)*
- ❑ Patient Preference
- ❑ Behavioral Health

Transitional/Continuity of Care Request

- ❑ Maternity Related *(Patient in second or third trimester)* Expected Delivery Date: ______________
- ❑ Doctor/Hospital termed from network during treatment *(Doctor/Hospital must fill in the facts below)*
- ❑ Patient's network changed during treatment *(Doctor must fill in the facts below)*
- ❑ Complex medical and/or behavioral health conditions *(Doctor must fill in the facts below)*

Please include any extra comments you would like considered on your request:

____

____

Patient Signature: X ______________________________ Date: ______________

This form must be signed by the patient to be processed. Not complete requests will be returned.

Clinical Information to Support Transitional/Continuity of Care Request

(To Be Completed By Facility)

Note to Facility: 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 facility:

____

____

____

You may also submit medical records you would like considered for this request:

____

Facility Repesentative Signature: X ______________________________ Date: ______________

This request is not valid until approved by BlueCross BlueShield of Tennessee
(if approved, the approved visits must be completed within 6 months of the approval date).
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

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