

Patient Name		Patient ID Number	Patient Date of Birth
Patient Street Address			
City		State	ZIP Code
Specialty		Requested Provider's Name	
Doctor Street Address		Doctor PIN# or Tax ID #	
City		State	ZIP Code
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 provider facts.

Network Availability Issue Request

- | | |
|--|---|
| <input type="checkbox"/> There are not any network Doctors/Hospitals available in my area | <input type="checkbox"/> Patient Preference |
| <input type="checkbox"/> I am new to this network <i>(and my Doctor/Hospital does not participate in this network)</i> | <input type="checkbox"/> Behavioral Health |

Transitional/Continuity of Care Request

- Maternity Related *(Patient in second or third trimester)* Expected Delivery Date: _____
- Doctor/Hospital terminated 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 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.

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

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: _____

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

Provider 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.**