SCOTT & WHITE HEALTH PLAN
Texas Friendly

TPA Group Member

Transition of Care Request Form

The information requested below will help us assist you as you transition onto coverage under your Scott and White Health Plan (SWHP) Standard Plan Document (SPD). Please sign below to release information that will enable SWHP to assist in answering any questions you may have regarding healthcare services and to facilitate the transition of your current healthcare services. **This release does not allow us to speak to or release protected health information to anyone other than a provider of healthcare services or payor of healthcare benefits.** The information you provide will not limit or exclude any benefits under the terms of your insurance contract. Please complete the form below and return to:

Scott and White Health Plan
2401 South 31st Street
Temple, TX 76508
Attention: Customer Service
OR
You may fax the form to:
Scott and White Health Plan
Customer Service Department
FAX: 254-298-3385

Your Name: ______________________________ Your Date of Birth: ______________

Employee's Name: ______________________________ Relation to You: ______________

Employee's Member Number (if known): ______________ Date of Birth: ______________

Employer: ______________________________ Effective Date of Coverage: ______________

Home Telephone Number: (_______) ______________ Best Time to Call: _______ AM/PM

Work Telephone Number: (_______) ______________ Best Time to Call: _______ AM/PM

**Have you selected a Network or non-Network physician who will be assisting you to coordinate your care? _____Yes _____ No

If "Yes", who is the Physician? (full name/location/phone number please)

____

____

If "No", what type of physician will you request SWHP work with to coordinate your care?

____

♦ SWHP recommends that you choose from one of the following primary care type services, as appropriate: ___Family Practice___ Internal Medicine____ Pediatrics___ Other: ______________
(Please indicate specialty)

______________________________ ______________

Patient or Member Signature Date/Time

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