COMMUNITY FIRST HEALTH PLANS

Request for Continuity/Transition of Care

Name (Employee): _____

Member ID (Employee): _____ Daytime Phone: _____

Name (Patient): _____

Street Address: _____

City/State/Zip: _____

Attending Physician: _____

Physician Phone: _____

Street Address: _____

City/State/Zip: _____

Proposed Facility: _____

Proposed Specialist to Serve as PCP: _____

Diagnosis/Condition Treatment: _____

_____

_____

_____

_____

Certification & Medical Authorization

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to this request. I certify that the information I furnish in support of this request is true and correct.

Signed (Employee): _____ Signed (Patient): _____

Mail or fax form to:

Community First Health Plan
PHM Department
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
Fax: 210-358-6387

Community First Health Plans Use Only

Comments: _____

_____

_____

CFHP Accept Case Reject Case

Signature: _____ Date: _____