# Community First Health Plans

## Request for Continuity / Transition of Care

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|---|---|
| Name (Patient/Member) | Attending Physician |
| Member Number | Physician Phone |
| Daytime Phone # | Street Address |
| Name (Person Completing Form) | City / State / Zip |
| Street Address | Proposed Facility |
| City / State / Zip | Signature of Proposed Specialist to Serves as PCP |

DIAGNOSIS/CONDITION/TREATMENT ______________________________________________

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## CERTIFICATION AND 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 (Specialty Care Provider) ________________________________

Signed (Member) ________________________________________

Mail or fax form to HSM Department, Community First Health Plans, 12238 Silicon Drive, Suite 100, San Antonio, Texas 78249 – (210) 358-6040

## COMMUNITY FIRST HEALTH PLANS USE ONLY

Comments ____________________________________________________________

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***Community First Health Plans*** ☐ Accept case ☐ Reject case

Medical Director Signature ______________________________ Date ____________________