

## Community First Health Plans Request for Continuity/Transition of Care

\_\_\_\_\_  
Name (Employee)

\_\_\_\_\_  
Social Security Number (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 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 (employee) \_\_\_\_\_

Signed (patient) \_\_\_\_\_

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

#### COMMUNITY FIRST HEALTH PLANS USE ONLY

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Community First Health Plans  Accept case  Reject case

Signature \_\_\_\_\_ Date \_\_\_\_\_