

Community First Health Plans
Request for Continuity / Transition of Care

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 _____

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 _____

Community First Health Plans Accept case Reject case

Medical Director Signature _____ Date _____