Blue Cross and Blue Shield of New Mexico

Transitional Care Request

This form is to be filled out by the **physician** for any Blue Cross and Blue Shield of New Mexico (BCBSNM) member who requires ongoing care for an existing medical condition.
NOTE: The treatment plan must be as specific as possible, including completion date of treatment.

Insured Member's Name:
_____

Patient's Name:
_____

Patient's Address:
_____
_____
_____

Certificate Number: _____

Patient's DOB: _____

Patient's Phone Number: _____

Current Physician: _____**NPI #:** _____

Diagnosis/Treatment Plan:
_____
_____
_____

Expected completion date for this plan of care: _____

Physician's Signature: _____ **Date:** _____
Physician's Name (please print): _____
Physician's Phone Number: _____
Physician's Fax Number: _____
If the physician's office has not received a response from BCBSNM within 10 working days, please contact Health Services by telephone at 1-800-325-8334.

Fax this form to:
BCBSNM Health Services
Attention: Transition of Care
Fax Number: 505-816-3608