New Enrollee Transition of Coverage Request

What is Transition of Coverage? Transition of Coverage is a program offered by Florida BLue and Health Options (BCBSF/HOI) that allows new members who meet specific criteria, as defined by Florida Blue/HOI, to receive benefits at the in-network level from an out-of-network provider for a specific period of time. **Transition of Coverage is offered as a courtesy** and is not a benefit under a member's health plan. It is subject to approval by Florida Blue/HOI and may be discontinued at any time. Examples of potential conditions that may be eligible for Transition of Coverage include: Pregnancy, surgical procedures that have already been scheduled; current cycle of chemotherapy or radiation treatment; or transplants that have already been scheduled. To determine if your situation meets the eligibility criteria, complete, sign and fax this form to (904) 357 – 6536 or mail to P.O. Box 1798, Jacksonville, FL 32231.

Special situations: **Pregnancy** - New enrollees who are in their last three months of pregnancy as of the effective date with Florida Blue/HOI who wish to continue to receive care from a provider who is not in the applicable Florida Blue/HOI network for the member's health plan are encouraged to complete a Transition of Coverage request form.

Date	Name of Group/ Employer	Group Effective Date
Employee Name Last First MI		Employee Date of Birth
Employee Address Street City		State Zip
Patient's Name Last First MI		Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child
Home Phone	Business Phone	Previous Insurance Carrier
In which BCBSF/HOI product are you enrolled? ☐ BlueOptions ☐ BlueChoice		
Scheduled Surgery	**Pregnancy**	**Other Serious Medical Conditions**
Hospital/Surgical Facility:	Expected Delivery Date:	Diagnosis:
Procedure:	Hospital:	Physician Managing Care:
Diagnosis:	Name of Obstetrician:	Physician's Office Phone Number: ( ) -
Name of Surgeon:	Obstetrician's Phone Number: ( ) -	Date of First Office Visit:
Surgeon's Phone Number: ( ) -	Date of First Office Visit:	Date of Most Recent Office Visit:
Date of Scheduled Procedure	Date of Most Recent Office Visit:	Medication/Procedure:

Authorization To Obtain Information

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Patient Name Patient Date of Birth Subscriber Name

I hereby authorize physician(s), hospital(s), other healthcare providers, health care agencies, health maintenance organizations, and/or insurance companies possessing medical information concerning the patient indicated above to release to Blue Cross and Blue Shield of Florida, Inc. any and all medical information regarding the above-referenced course of treatment for the stated individual. This authorization specifically includes, without limitation, the release of past, present or future: HIV test results, alcohol and drug abuse treatment, psychological /psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions. This authorization expires six months from the date of this release unless otherwise indicated or revoked earlier.

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Signature of Patient or Patient's Legal Representative Relationship to Patient Date Signed

This information will be used to determine eligibility for Transition of Coverage. Data collected is protected in accordance with BCBSF privacy and confidentiality policies and federal and state regulations.