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 _____