brms

TRANSITION OF CARE FORM

Assistance Request

SUBCRIBER INFORMATION

Subscriber Name: ______________________ Subscriber SSN or ID #: ______________________

Employer: ______________________ Subscriber Date of Birth: ______________________

Address: ____

Phone Number(s) : ______________________ Email: ______________________

Patients Name: ______________________ Relation to Subscriber: ☐ Spouse ☐ Son ☐ Daughter ☐ Other

TRANSITION OF CARE INFORMATION

List the Provider(s) and/or Facility(ies) you need to have approved for Transition of Care below :

Doctors Name: ______________________

Phone #: ______________________

Facility Name (*if applicable*): ______________________

Facility Phone #: ______________________

Doctors Name: ______________________

Phone #: ______________________

Facility Name (*if applicable*): ______________________

Facility Phone #: ______________________

Current Diagnosis: ______________________

Current Treatment(s): ______________________

My Medical Need(s) Is/Are *(Check all that Apply)*:

- ☐ Surgery
- ☐ Radiation
- ☐ OP Mental Health
- ☐ Pregnancy and Immediate Post Partum
- ☐ Care of Newborn
- ☐ Acute/Serious Chronic Condition
- ☐ Surgical Follow Up Care
- ☐ Chemotherapy
- ☐ Transplant
- ☐ Terminal Illness
- ☐ Specialist(s)

Do you have any Hospitalizations, Surgeries or Procedures Scheduled ? ☐ Yes ☐ No

Scheduled Appointment Date: ______________________

Type of Surgery/Procedure: ______________________

Please provide us with as much detail about the item(s) marked above:

Signature: ______________________ Date: ______________________

If completed on behalf of the subscriber:

Name of Requestor: ______________________ Relation to Subscriber: ______________________

Requestor Phone #: ______________________ Date: ______________________

FORM SUBMISSION & QUESTIONS

PHONE: (800) 368-0767

EMAIL: ManagedCare@brmsonline.com

SECURE FAX: (916) 467-1403

MAIL: BRMS
Attn: Medical Management
80 Iron Point Cr., Suite 200
Folsom, CA 95630