SCOTT & WHITE HEALTH PLAN
Texas Friendly

Commercial Group Member
Transition of Care Request Form

The information requested below will help us assist you as you transition onto coverage under your Scott and White Health Plan (SWHP) Evidence of Coverage. Please sign below to release information that will enable SWHP to assist in answering any questions you may have regarding healthcare services and to facilitate the transition of your current healthcare services. **This release does not allow us to speak to or release protected health information to anyone other than a provider of healthcare services or payor of healthcare benefits.** The information you provide will not limit or exclude any benefits under the terms of your insurance contract. Please complete the form below and return to:

Scott and White Health Plan
2401 South 31st Street
Temple, TX 76508
Attention: Customer Service
OR
You may fax the form to:
Scott and White Health Plan
Customer Service Department
FAX: 254-298-3385

Your Name: ______________________________ Your Date of Birth: ______________

Employee's Name: __________________________ Relation to You: ________________

Employee's Member Number (if known): _____________ Date of Birth: _______________

Employer: ___________________________ Effective Date of Coverage: ____________

Home Telephone Number: (_______) ________________ Best Time to Call: ______ AM/PM

Work Telephone Number: (_______) ________________ Best Time to Call: ______ AM/PM

**Have you selected a SWHP Primary Care Physician (PCP)? _____Yes _____ No

If "Yes", who is the PCP?____

If "No", what type of PCP will you request? __Family Practice __Internal Medicine __Pediatrics

____ ____________________
Patient or Member Signature Date/Time

**You will be required to choose a network PCP on your actual enrollment form. DO NOT use this form for this purpose. This form is for coordination/transition of current care in process.