ERS
Employees Retirement System of Texas

KelseyCare powered by Community Health Choice

Return this form to:
KelseyCare powered by
Community Health Choice
PO BOX 841569
PEARLAND, TX 77584-9832
Fax: (713) 442-2798

Transition of Care Request Form

Member Information

First Name: _____ Middle Initial: _____ Last Name: _____

Member ID Number: _____ Date of Birth:___/___/_____Effective Date:___/___/ _____

Type of Request:

☐ Radiation/Chemotherapy ☐ Surgery ☐ Physical Therapy

☐ Durable Medical Equipment ☐ Home Health ☐ Pregnancy

☐ Other - Please specify: _____

What services from non-network providers do you believe you need to continue receiving?

_____

_____

Please list the contact information of the providers you are using:

Provider Name: _____

Provider Address: _____ Provider Phone Number: _____

What services are you receiving from this provider? _____

Provider Name: _____

Provider Address: _____ Provider Phone Number: _____

What services are you receiving from this provider? _____

Provider Name: _____

Provider Address: _____ Provider Phone Number: _____

What services are you receiving from this provider? _____

I hereby authorize the above provider(s) to give KelseyCare powered by Community Health Choice any and all information and medical records necessary to make an informed decision concerning my request for transition of care under KelseyCare powered by Community Health Choice. I understand I am entitled to a copy of this authorization form.

Signature of Patient: _____ Date (mm/dd/yyyy) _____

Signature of Guardian (if applicable): _____ Date (mm/dd/yyyy) _____