# Member Request for Transitional Care Benefits and Release of Information

Please complete this form if you are currently receiving medical care from physician(s) that are not listed in your provider directory and would like assistance in coordinating your medical care. It may be necessary to request medical information from your current physician(s). Transitional Care Benefits, for covered services, may be available for up to 90 days after your provider leaves the network or your group coverage ends. After 90 days, the Medical Director will review any requests for benefits, made in writing, according to our standard prior authorization review process.

**Providers not in the network may still bill for charges over the plan's allowed amount.**

Group Name: _____ Group Number: _____

Employee Name: _____ ID# / SS# _____ Date of Birth: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Relationship to Employee: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: Home: _____ Work: _____ Cell: _____

MEDICAL INFORMATION

What is the Health Condition, Diagnosis or Treatment Plan for which the Patient is seeking Transitional Benefits? _____

| | | | |
|---|---|---|---|
| Is the Patient receiving care for a Pregnancy? | Yes ☐ | No ☐ | If Yes, what is the estimated due date? _____ |
| Is there a Surgery scheduled or recently done? | Yes ☐ | No ☐ | If Yes, what is/was the date of the surgery? _____ |
| Is the Patient currently on a Transplant list? | Yes ☐ | No ☐ | If Yes, please provide a copy of the approval letter. |
| Does Patient have a Physician appointment scheduled? | Yes ☐ | No ☐ | If Yes, please indicate the date of the Patient's next appointment. _____ |

PHYSICIAN INFORMATION

| Physician Name | Address | Phone # | |
|---|---|---|---|
| | **Name of Facility (Hospital, DME, group)** | **Date of Last Visit** | **Date of Next Visit** |
| **Physician Name** | **Address** | | **Phone #** |
| | **Name of Facility (Hospital, DME, group)** | **Date of Last Visit** | **Date of Next Visit** |
| **Physician Name** | **Address** | | **Phone #** |
| | **Name of Facility (Hospital, DME, group)** | **Date of Last Visit** | **Date of Next Visit** |

A Fund representative may contact you to obtain medical records for clinical review.

What is the best number to reach you? Home: _____ Work: _____

I hereby authorize the Central Laborers' Welfare Fund Director or designee to obtain any information and medical records from the above physician(s) / provider(s) in connection with making an informed decision regarding my request for Treatment in Progress (Transitional Care benefits) under the Central Laborers' Welfare Fund Plan. I understand that I am entitled to a copy of this Authorization Form.

Signed: (Patient or Guardian) _____ Date: _____

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|---|---|---|
| Return form to: | Fax: 1-217-243-8619 | Mail: Central Laborers' Welfare Fund<br>PO Box 1267<br>Jacksonville, IL 62651-1267 |