

Health Care Transition of Care Request Form *(continued)*

Please complete the health care professional information request below.

Group Practice Name		
Health Care Professional Name	Health Care Professional Phone#	
Health Care Professional Specialty	Provider Tax ID # (if applicable)	
Health Care Professional Address		
Hospital Where Health Care Professional Practices	Hospital Phone #	
Hospital Address		
Reason/Diagnosis		
Dates of Admission <i>(mm/dd/yyyy)</i>	Date of Surgery <i>(mm/dd/yyyy)</i>	Type of Surgery
Treatment Being Received and Expected Duration		

NOTE: All TOC requests will be reviewed within 10 days of receipt of all necessary information. Organ Transplant requests may take additional time.

I hereby authorize the above provider to give Allegiance Benefit Plan Management, Inc. any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care coverage under The Plan. I understand I am entitled to a copy of this authorization form.

Signature of Patient, Parent or Guardian

Date *(mm/dd/yyyy)*

Please return form to:

Allegiance Benefit Plan Management, Inc. | Attention: Claims
PO Box 21074 | Eagan, MN 55121 | Toll Free Fax: 1-866-201-0522