



NEBRASKA

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Case Management Transition Form

If you are in need of case management services, please complete this form. If you need more space for any answers, you can use a separate piece of paper. Please include your name and group name on the extra sheet(s) of paper. **Please print using black ink.**

1) Employee Name: (First, M.I., Last)	2) Date of Birth: mm/dd/yy	3) Group Name: <i>City of Lincoln - 305008</i>	4) Effective Date of coverage with BCBSNE:
5) Home Phone: (include area code)	6) If you would like to be contacted at work, please provide your number:		7) Best time to call:

A. Do you or any of your dependent(s) receive any of the following services?

Services	Service/Equipment currently being provided	Member Name (First, M.I., Last)	Provider Name and Phone Number
Home Health			
Medication and IV fluids at home			

B. Please list any pending surgical procedures or inpatient admissions.

Procedure	Date Scheduled	Member Name (First, M.I., Last)	Provider Name and Phone Number

C. Please list any history of transplants or other major surgeries/illnesses

Transplant Surgery/Illness	Date of Surgery/Illness	Member Name (First, M.I., Last)	Provider Name and Phone Number

D. Have you ever participated in a case management program? If yes, please list the reason and dates of participation:

Fax or mail this form to: Attention: HSP
 Blue Cross and Blue Shield of Nebraska
 P.O. Box 3248
 Omaha, NE 68180-0001

Fax: (402) 392-4141

Completing this form does not guarantee continued payment of services. The amount of benefit coverage, if any, is subject to all plan provisions including member eligibility and any contractual limitations in effect when services provided. All applicable co-payments, coinsurance, and deductibles apply. Please review your policy for benefit questions. You **MAY** be contacted by Case Management based on the information submitted.