Fax

Post-Acute Transitions of Care Authorization Form

To: Transitions of Care

Fax: **410-505-2588**

Date:

From:

Office Phone:

Cell Phone:

Number of pages Including cover sheet:

Dear Provider,

Please complete all fields below and include all current (within past 24-48 hours) PT/OT/ST or pertinent clinical information for the requested service.

This is a concurrent request, a decision will be completed and communicated within 1 business day once all required information is received.

Member Name: ___________________________________ CareFirst ID number ____________________

Current Location of the member: ____

Requested Level of Care: ____________________________________

Receiving Facility: ____

Date of Admission to Receiving Facility: ________________________

Primary Diagnosis: ____

Attending Physician (current or at Facility): ____

Contact information for Receiving Facility: __________________ (name) ___________________ (phone)

Address of Receiving Facility: ____

City: _________ State: __________ Zip Code: ______________

Confidentiality Notice

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