



Return to:

Be Well @ Shell Kelsey-Seybold Health Plan
11511 Shadow Creek Parkway
Pearland, TX 77584
Attn: Kelsey UM

What is Transition of Care?

With Transition of Care, you may be able to continue to receive services for specified medical or behavioral conditions with healthcare professionals who are not in the **Be Well @ Shell** Kelsey-Seybold Health Plan. This care is for a defined period of time until the safe transfer of care to a Kelsey-Seybold approved provider or facility. You must apply for Transition of Care no later than 30 days after the effective date of your coverage.

Patient Information

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

Phone Number: _____ Date of Birth (mm/dd/yyyy): _____

Insured Information

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

Social Security Number: _____ Relationship to Patient: Spouse Dependent Self

Type of Request:*

Radiation/Chemotherapy Surgery Physical Therapy
 Durable Medical Equipment Home Health Pregnancy – Due Date (mm/dd/yyyy): _____
 Other – Please specify: _____

*** For behavioral health related services (mental health/substance abuse care), please contact Cigna Behavioral Health by calling 1-855-279-1509.**

For what services are you requesting Transition of Care?

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? _____

I hereby authorize the above provider(s) to give the **Be Well @ Shell** Kelsey-Seybold Health Plan any and all information and medical records necessary to make an informed decision concerning my request for transition of care under the **Be Well @ Shell** Kelsey-Seybold Health Plan.

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): _____