Blue Care Network of Michigan

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Away From Home Care
Transfer of Medical Information Request

Member Instructions

If accessing this form online, please print a copy. Complete parts A and B. Have your Home Primary Care Physician complete parts C, D and E. Take the completed form to the physician who will be providing the follow-up care (Host physician) in the out-of-area location. The member is responsible for any copayments for follow-up treatment.

Part A: Contract Information

Subscriber's last name	First name	Initial
Contract number	Phone number	Date

Subscriber's address	City	State	Zip code

Part B: Away From Home Information

Member's last name	First name	Initial

Member's address away from home	City	State	Zip code

Dates away from home From To	Phone number away from home

Emergency contact	Relationship	Phone number

Address	City	State	Zip code

Sex ☐ Male ☐ Female	Contract number	Date of birth (Mo-Day-Yr)

I hereby certify that all of the information stated above is truthful and correct to the best of my knowledge. I hereby authorize my Home and Host Physicians to exchange information about me.

Member signature _____ Date _____

Part C: Home Primary Care Physician Information

Please maintain a copy of the document with the patient's medical records.

Physician name	Phone number	Fax number

Address	City	State	Zip code

Part D: Type of Care Member Has Requested

Follow-up care for the following condition(s) while away (require PCP approval below):

Part E: Medical Information (to be completed by the Home PCP - use additional page if necessary)

Past medical conditions/co-morbidities and hospitalizations

Current medical conditions/co-morbidities and recent hospitalizations

Prescriptions/medications

Drug allergies or drug intolerances

Special diets

Physical limitations

Recent immunizations:

- ☐ Tetanus Date _____
- ☐ Pneumovax Date _____
- ☐ Influenza Date _____
- ☐ Other _____ Date _____

Durable medical equipment needs:

- ☐ Wheelchair
- ☐ Ambulatory assistance devices
- ☐ Oxygen
- ☐ Other _____

Skilled nursing needs:

- ☐ Feeding tubes
- ☐ IV therapy
- ☐ Urinary drainage
- ☐ Colostomy
- ☐ Dressing changes
- ☐ Other _____

Diagnostic/screening test within the past year:

- ☐ Coronary angiogram ☐ Stress test
- ☐ Mammography
- ☐ Endoscopy (list) _____
- ☐ Biopsy (list) _____
- ☐ Other _____

I give approval for the prescribed follow-up care:

_____ _____

Home physician signature Date

Part F: Host Physician Information

Please mail this form and any necessary medical information to the physician noted in **Part C.** Please maintain a copy for your files.

Physician name	Phone number	Fax number

Address	City	State	Zip code

Did member receive medical care? ☐ Yes ☐ No

New treatment or prescription? ☐ Yes ☐ No

Describe using additional pages as necessary

_____ _____

Host physician signature Date