BlueCross BlueShield of Illinois

FAX COVER SHEET

***IMPORTANT*: INCLUDE THIS COVERSHEET WITH FAXED MEMBER INFORMATION.**

ONLY FAX ONE (1) MEMBER PER TRANSMISSION.

DATE:	NUMBER OF PAGES (including coversheet):

RECIPIENT:	SENDER NAME:
PHONE: Blue Cross Community Health Plans[SM] (BCCHP): 877-860-2837 Blue Cross Community MMAI (Medicare-Medicaid Plan)[SM]: 877-723-7702	SENDER ORGANIZATION: SENDER PHONE:
FAX: Behavioral Health UM Requests Only: 312-233-4099 All other requests & documents: 312-233-4060	SENDER FAX:
ATTN:	

PROVIDER NAME:	MEMBER ID:
MEMBER NAME:	MEMBER GROUP:
MEMBER DOB:	

IS MEMBER COORDINATED BY A PHYSICAL HEALTH PARTNER or A BEHAVIORAL HEALTH PARTNER?

Check: ☐ PHYSICAL *or* ☐ BEHAVIORAL

DOCUMENTS INCLUDED IN FAX TRANSMISSION:	CHECK IF INCLUDED
BACK-UP PLAN	
COMPREHENSIVE HEALTH RISK ASSESSEMENT (CHRA)	
CONSENT FORM	
CRITICAL INCIDENT FORM	
HEALTH RISK ASSESSMENT (HRA)	
INDIVIDUALIZED CARE PLAN	
INPATIENT ADMISSION REQUEST	
INTERDISCPLINARY CARE TEAM	
MEDICAL RECORD	
MEMBER LETTER	
RISK MITIGATION PLAN	
OUTPATIENT TREATMENT REQUEST (OTR)	
PARTICPANT OUTCOMES & STATUS MEASURES (POSM)	
POWER OF ATTORNEY FORM	
PRIMARY CARE PHYSICIAN CHANGE FORM	
PRIOR AUTHORIZATON REQUEST	
REFERRAL	
SATISFACTION SURVEY	
SERVICE PLAN	
OTHER (explain):	

Rev 1/1/18

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