

Scott and White Health Plan Transition of Care

The information requested below will help us to assist you as needed during your transition period onto coverage under your Scott and White Health Plan (SWHP) Health Care Agreement. A release of information is requested below through your signature to be able to provide information to facilitate answering your questions and the transition of your current services. The information provided will NOT limit or exclude any benefits under the terms of the Health Care Agreement. Please complete the form below and mail to:

Scott and White Health Plan
2401 South 31st Street
Temple, TX 76508
Attention: Member Relations

OR

You may fax the form to:

Scott and White Health Plan
Member Relations Department
FAX: (254) 298-3385

NAME: _____ Date of Birth: _____

Subscriber's Name: _____ Relation to You: _____

Subscriber's Social Security Number: _____ - _____ - _____

Employer Group: _____ Effective Date of Coverage: _____

Home Telephone Number: (_____) _____ Best Time to Call: _____ AM/PM

Work Telephone Number: (_____) _____ Best Time to Call: _____ AM/PM

Have you already selected a SWHP Primary Care Physician (PCP)? Yes No

If "Yes", who is the PCP? _____

If "No", what type of PCP will you request? Family Practice Internal Medicine
 Pediatrics

Patient or Member Signature

Date/Time