BLUE CROSS BLUE SHIELD OF MICHIGAN
TRINITY HEALTH - MERCYONE GENESIS
TRANSITION OF CARE

Please complete a separate form for each member and facility/provider.
Deadline to submit requests is March 31, 2025

Colleague or Subscriber Information

First and Last Name	Date of Birth
Home Address	
Home Phone	Work Phone
Email Address	

Patient information

Patient name	Patient date of birth
Patient phone (if different from enrollee)	

Service type (select one) ***If selecting Acute or Chronic illness, please list illness/condition name (i.e. Asthma, diabetes, etc.)***

	Acute illness		Chronic illness
	Pregnant and undergoing a course of treatment for pregnancy		Scheduled non-elective surgery and postoperative care
	Receiving inpatient care		Receiving treatment for a terminal medical prognosis (life expectancy is less than six months)

Facility information

Facility Name	
Facility contact person (pertaining to your treatment)	Facility contact person phone

Physician information

Physician Name	Physician Phone
Physician Address	

Patient signature:_____ **Date:** _____

Submit the completed form to:

Blue Cross Blue Shield of Michigan
Email: trinitytransitionofcare@bcbsm.com
OR
Fax: 866-777-0901