



Missouri Care
AN AETNA HEALTH PLAN

CASE MANAGEMENT REFERRAL FORM

Patient Name: _____ DOB: _____ Referral Date: _____

Insurance Plan: _____ Member ID Number _____ Cob: Yes No

Member aware of Referral: Yes No

Referred By: [Name(s) of referral source]: _____

MS PA Medical Director Member Advocate Provider BH UP Medical UM Medical CM BK CM Other

Referral to: By: [Name(s) of referred to]: _____

Adult Team - CM Peds Team - CM Perinatal CM Disease Management

Concerns leading to referral: (check all that apply)

- Transplants
- Cardiovascular/stroke complications
- Kidnel/liver medical complications
- Chronic Pain
- Respiratory failure/complications
- TBI/Seisure disorder
- Cancer (new DX or treatment)
- Dementia with current complications
- Eating disorder with medical complications
- Complex/Multiple surgery
- Pregnancy
- Complex medical treatment
- HIV/Aids
- Diabetic
- Medical Trauma/burns
- Lead Exposure
- Child w/special needs - specify _____
- Hepatits
- Sicle Cell Anemia
- Anxeity Disorders
- Pervasive Developmental Disorders
- Child in Foster Care or on foster adoption subsidy
- Member transitioning onto/off of the plan (transition of care
- Domestic Abuse
- Suicidal/Homicidal aieation/Hx of attempts
- Serious Mentally Ill Disgnosis
- Substance Abuse
- Mental Health/Substance Abuse
- Unable to Navigate System on Own
- Lack of support and/or Resources
- Repeated non-compliance with Meds or Tx Plan
- Court Ordered Tx
- Eating Disorder
- AMA Discharge
- 2 or more IP admits within 6 months
- Excessive ER use
- Pregnancy with Serious Mental Illness/Substance Abuse
- Pospartum Depression

Indicate any treatment barriers:

- Housing
- No Phone
- Transportation
- Financial
- Provider Availability
- Lack of Support
- Physical Limitations
- Other

Current Diagnosis if known: _____

Current Medications if known: _____

Important case details: _____

Discharge Plan if Inpatient: _____

Current PCP/Phone Number _____ Current Specialist/Phone Number: _____

Referral: Accepted Denied

Date and CM Assigned: _____

Decision and Date of Notification to referral Source _____

Providers Can Fax Form to 1-866-946-1104