



CASE MANAGEMENT REFERRAL FORM

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

Patient Name: _____ DOB: _____ Referral Date: _____

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

Member's current Phone Number _____ POA/Guardian Name/Phone _____

Member aware of Referral YES NO

Referred by: [Name(s) of referral source]

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

Referral to: [Names(s) of referred to]

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

Concerns leading to referral: (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Transplants | <input type="checkbox"/> Cardiovascular/Stroke complications | <input type="checkbox"/> Kidney/liver medical complications |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Respiratory failure/complications | <input type="checkbox"/> TBI/Seizure disorder |
| <input type="checkbox"/> Cancer (new Dx or treatment) | <input type="checkbox"/> Dementia with current complications | <input type="checkbox"/> Eating disorder with medical complications |
| <input type="checkbox"/> Complex/multiple surgery | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Complex medical treatment |
| <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Diabetic | <input type="checkbox"/> Medical trauma/burns |
| <input type="checkbox"/> Lead Exposure | <input type="checkbox"/> Child w/ special needs – specify _____ | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Pervasive Developmental Disorders |
| <input type="checkbox"/> Children in Foster Care or on foster or adoption subsidy | <input type="checkbox"/> Member transitioning onto/off of the plan (transition of care) | <input type="checkbox"/> Domestic Abuse |
| <input type="checkbox"/> Suicidal/Homicidal ideation/Hx of attempts | <input type="checkbox"/> Serious Mentally Ill Diagnosis | <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health/Substance Abuse |
| <input type="checkbox"/> Unable to Navigate System on own | <input type="checkbox"/> Lack of support and/or Resources | <input type="checkbox"/> Repeated non-compliance with Meds or Tx Plan |
| <input type="checkbox"/> Court Ordered Tx <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> AMA Discharge <input type="checkbox"/> 2 or more IP admits within 6 months | <input type="checkbox"/> Excessive ER use |
| <input type="checkbox"/> Pregnancy with Serious Mental Illness/Substance Abuse | <input type="checkbox"/> Postpartum Depression | |

Indicate any treatment barriers:

- | | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Housing | <input type="checkbox"/> No Phone | <input type="checkbox"/> Transportation | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Provider availability | <input type="checkbox"/> Lack of Support | <input type="checkbox"/> Physical Limitations | <input type="checkbox"/> 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 _____

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