Case/Disease Management Referral Form

Please complete all applicable sections of this form, indicating whether the member is being referred for a telephonic assessment by a Nurse, Social Worker, Registered Dietitian or all. Please attach all supporting documentation, including pertinent medical records, testing and office notes.

Referral Date: _____ Referred By: _____ Phone: _____

(Provider Name) (Provider Phone Number)

Primary Office Contact for Information: _____

Member Name: _____ ID #: _____

Member DOB: _____ Member Phone #: _____

Reason for Referral:

I. Nursing Case Management Needs

- ☐ Uncontrolled Diabetes
- ☐ COPD/Asthma Complications
- ☐ Transplant
- ☐ CVD (specify below)
- ☐ CHF
- ☐ Wounds (unhealed over 30 days.)
- ☐ OB
- ☐ HIV/AIDS
- ☐ Multiple Events (≥2 hospital admissions in 30 days, multiple ER visits, etc.)
- ☐ Multiple Comorbidities
- ☐ Frequent Falls
- ☐ Other _____

Additional Comments:

II. Dietitian Case Management Needs

- ☐ Diabetes Nutrition Management
- ☐ Heart Healthy Diet Education
- ☐ COPD Diet Education
- ☐ Weight Management
- ☐ Healthy Eating Habits
- ☐ Other _____

Additional Comments:

III. Social Services Case Management Needs

- ☐ Financial (utilities, etc.)
- ☐ Food Assistance
- ☐ Member is in coverage gap
- ☐ Copay Assistance
- ☐ Behavioral Health
- ☐ Transportation Barriers
- ☐ Other _____

Additional Comments:

Please Fax this form and any supporting documentation to **1-888-314-0794**.
Case Management Department general phone: 1-888-211-9913 ext.11238.

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