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.

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.

Revised 3/10/2022