

## Case/Disease Management Referral Form

Please complete all applicable sections of this form, indicating whether the member is being referred to a Nurse, Social Worker, or both.

Referral Date: \_\_\_\_\_

Referred By: \_\_\_\_\_  
(Provider Name)

Phone: \_\_\_\_\_  
(Provider Phone Number)

Primary Office Contact for Information: \_\_\_\_\_

Member Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Member DOB: \_\_\_\_\_ Member Phone #: \_\_\_\_\_

### Reason for Referral:

#### I. Nursing Needs

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

#### Additional Comments:

#### II. Social Services 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.