



Case Management Referral Form

Population Health Management Programs and Process			
Program	Frequency	Duration	Description
Complex Case Management Responsible: Nurse Case Manager	Contact minimum of 1 to 2 times monthly. May be high intensity at onset and decrease to monthly.	Duration for greater than 6 months or until needs and goals are met. May transition to another program if needs decrease.	Patients who are at high risk, defined as having medically complex conditions that include, but are not limited to, the following: <ul style="list-style-type: none"> ✓ Spinal Injuries ✓ Transplants (with additional complex condition) ✓ Cancer (with additional complex conditions or mets) ✓ Serious Trauma ✓ AIDS ✓ Multiple Chronic illnesses ✓ Chronic illness that results in high utilization
Care Coordination Management Responsible: Nurse Case Manager	Contact minimum of 1 to 2 times monthly based on issues and burden of illness.	Duration of 60 to 90 days or until goals are met. May transition to another program if needs increase or decrease.	Patients who are at a moderate risk but have an acute or chronic medical condition that requires assessment and coordination of resources in to maintain the patients in the least restrictive setting.
Basic Service Coordination Management Responsible: Nurse Case Manager and/or Support Specialist	Contact of once a month or as needed based on service coordination needs.	Duration of up to 1 month or until goals are met.	Patients with stable medical conditions who require access to services, health coaching, or referrals to resources.



Case Management Referral Form

Date: _____

Member Name:	Date of Birth:	Member ID#:
Member Phone#:	Requested by:	Requester #:
Primary Language:	PCP (name):	Legal Guardian:

Choose Program Type – check Program type and items that apply for the member

<input type="checkbox"/> Complex Care Management	<input type="checkbox"/> Care Coordination	<input type="checkbox"/> Basic Service Coordination
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Reason for Referral (check all that apply)

<input checked="" type="checkbox"/> Two or more active chronic diagnoses; CHF, COPD, ESRD, CKD 4-5, CRF (specify below)	<input type="checkbox"/> Financial concerns with obtaining meds, housing, food, and/or utilities. (specify below)	<input type="checkbox"/> 2 or more unplanned hospital admissions/6 months	<input type="checkbox"/> Assistance in obtaining community resources
<input type="checkbox"/> History of non-adherence with plan of care	<input type="checkbox"/> 10 or more daily medications (provide med list if available)	<input type="checkbox"/> 2 or more ED visits/6 months	<input type="checkbox"/> Sudden catastrophic illness i.e. ALS, CA with mets, TBI (specify below)
<input type="checkbox"/> Inadequate support Systems (specify below)	<input type="checkbox"/> Unstable living Situation (specify below)	<input type="checkbox"/> 2 or more behavioral health admits	<input type="checkbox"/> Moderate to Severe memory impairment
<input type="checkbox"/> Multiple falls with severe fall risk	<input type="checkbox"/> End stage disease care planning needs	<input type="checkbox"/> Sudden disability and/or increase in ADL assistance	<input type="checkbox"/> Other (specify below)

Additional Detail

Please fax completed form to: Care Management Department (512) 960-2301

For questions regarding referrals, call the Population Health Management Customer Service Team at (737) 236-0999 or toll free at (833)-282-8883