949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

# CCS LEVEL 5 REFERRAL FORM
# SEND VIA FTP

| Member | |
|---|---|
| Member Plan ID: | Today's Date: |
| Member Last Name: | Member First Name: |
| Member Phone Number: | Date of Birth: |
| Alternate Phone Number: | Home Address: |
| Medicaid ID: | CCS Effective Enrollment Date: |
| Is Member Homeless? ☐ Yes ☐ No | |
| If Homeless, Current or Last Known Whereabouts: | |
| **Legal Guardian** | |
| Legal Guardian Name: | Legal Guardian Relationship: |
| Legal Guardian Phone Number: | Legal Guardian Address: |
| **Treating Case Management Provider** | |
| Provider ID: | |
| Case Management Agency: | |
| Phone Number: | Fax Number: |
| Case Manager Name: | Case Manager Phone Number: |
| **Diagnosis** | |
| ICD-10 Diagnosis Code: | Description: |
| ICD-10 Diagnosis Code: | Description: |
| Medical Conditions: | |
| Current LOCUS: | |
| **Primary Care Provider** | |
| Primary Care Provider's Name: | |
| Phone Number: | Fax Number: |
| **Treating Psychiatrist** | |
| Treating Psychiatrist's Name: | |
| Phone Number: | Fax Number: |

**What are the goals of member's Level 5 Case Management services that would allow the member to step down to traditional levels 1-4 CBCM case management?**

| Target Objectives |
|---|
| |


©WellCare 2018