P.O Box 31224 Tampa, FL 31224
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Phone: 800 322 6027
Please Fax to 866-946-1104

Case Management Referral Form

Referral Date:	Is member aware of referral: ☐yes ☐ no	Referred To: ☐CM ☐ DM
Member Name:		DOB:
DCN Number:	Member's Phone Number:	
Member's Address:		
POA Guardian Name:	POA Guardian Phone Number:	
Other Insurance Carrier: (If Applicable)	Policy # (If Known)	
Name of Person Referred By:	Referred By Contact Number:	

Reason for Referral: (Check All That Apply)

☐ Transplant	☐ Cardiovascular / Stroke Complications	☐ Kidney / Liver Disease
☐ Chronic Pain	☐ Respiratory Failure / Complications	☐ TBI / Seizure Disorder
☐ Cancer (New dx or treatment)	☐ Dementia with Current Complications	☐ Eating Disorder with Medical Complications
☐ Complex Multiple Surgery	☐ Pregnancy	☐ Complex Medical Treatment
☐ HIV / AIDS	☐ Diabetic	☐ Medical Trauma / Burns
☐ Lead Exposure	☐ Sickle Cell Anemia	☐ Hepatitis ☐ B ☐ C
☐ Anxiety Disorder	☐ Pervasive Developmental Disorders	☐ Domestic Abuse
☐ Unable to Navigate System on Own	☐ Serious Mentally Ill Diagnosis	☐ Substance Abuse
☐ Mental health / Substance Abuse	☐ Court Ordered Tx	☐ Eating Disorder
☐ AMA Discharge	☐ Lack of Support and / or Resources	☐ 2 or More IP admits within 6 mos
☐ Repeated Non-Compliance with Meds or Tx Plan	☐ Excessive ER Use	☐ Suicidal / Homicidal Ideation Hx of Attempts:
☐ Postpartum Depression	☐ Pregnancy with Serious Mental Illness/ Substance Abuse	☐ Children in Foster Care or on Foster or Adoption Subsidy
☐ Member transitioning onto / off the plan (transition of care)	☐ Child with special needs - specify	

Barriers to Treatment: (Check All That Apply)

☐ Housing	☐ Provider Availability	☐ No Phone
☐ Lack of Support	☐ Transportation	☐ Physical Limitations
☐ Financial	☐ Other: (Specify)	
Current Diagnosis: (if known)	Current Medications: (if known)	
Important Case Details: (if known)		
Current PCP:	PCP Phone Number:	
Current Specialist:	Specialist Phone Number:	

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