CASE MANAGEMENT REFERRAL FORM

To: Preferred Administrators **ATTN: Case Management** Phone: (915) 532-3778 ext. 1500 **Fax: 915-298-7866**	FROM:_____ **(Physician's Office Name)** OFFICE CONTACT PERSON:_____ FAX NUMBER:_____ TELEPHONE NUMBER:_____

Member Name:	**Member ID #:**	**DOB:**
Member Contact Number:	**Member Address:**	

REASON FOR REFERRAL (check all that apply and add comments when applicable):

- ☐ **HIGH RISK PREGNANCY**
- ☐ **BEHAVIORAL HEALTH**
- ☐ **ASTHMA**
- ☐ **HEART DISEASE**
- ☐ **DIABETES**
- ☐ **SPECIAL HEALTH CARE NEEDS (i.e. chronic, complex condition expected to last longer than 12 months)**
- ☐ **SOCIAL WORK**
- ☐ **OBESITY**

PRESENTING CONCERN:

- ☐ Assistance locating covered services
- ☐ Coordination of care
- ☐ Non-compliance with treatment plan
- ☐ Patient education (i.e. symptom management, self-management strategies, diabetes education)
- ☐ Assistance accessing treatment for behavioral health diagnosis
- ☐ Social concerns, please specify concern(s): _____
- ☐ High risk pregnancy, please specify condition/concern:_____