



Care Management Referral Form

Send completed forms to: Kevin.Dame@carelon.com	FROM:	
	Referrer Name & Title:	
	Referrer Phone:	
	Referrer Email Address:	
Is this an URGENT request? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(If yes, describe in detail below)</i>		
<i>Urgent requests are for cases that need same-day outreach. All non-urgent cases will be outreached within two business days (Monday-Friday 8:30am-5:00pm).</i>		
MEMBER INFORMATION		
Member Name:	Member ID:	Member DOB:
Member contact information, including collateral contacts:		
Language spoken:		
Health Home / CMA contact information:		
PCP/Specialist contact information:		
Is the member able to make decisions on their own behalf and provide consent? <i>For members who cannot provide consent, HCP paperwork is required for CM outreach.</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the member aware of this referral?		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the member connected with any of the following services?		
<input type="checkbox"/> Assertive Community Treatment (ACT)		
<input type="checkbox"/> Comprehensive Psychiatric Emergency Program (CPEP)		
<input type="checkbox"/> Personalized Recovery Oriented Services (PROS)		
<input type="checkbox"/> Community Oriented Recovery and Empowerment (CORE) Services		
<input type="checkbox"/> Other <i>(please describe below)</i>		
Reason(s) for Referral <i>(Indicate all that apply):</i>		
<input type="checkbox"/> Determine behavioral health need (mental health or substance use)		
<input type="checkbox"/> Assist with coordination of care and/or referrals		
<input type="checkbox"/> Participation or collaboration in treatment planning		
<input type="checkbox"/> Other <i>(please describe below)</i>		



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Describe your reasons for requesting case management, including behavioral health diagnosis (if known), current behavioral health treatment member is receiving (if any), current providers, and a summary of the member's request. If **URGENT** request, please include circumstances here:

Medical diagnoses that may impact case management:

Functional Impairments that may impact case management:



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