

Special Needs/Case Management Referral Form

Please send referrals: PACMReferralMailbox@aetna.com or fax to: 877-683-7354

All fields must be completed for processing of the referral

Date of Referral: _____ ABH Plan Type: _____ Primary COB: _____

Member Name: _____ POA/Guardian/Parent Name: _____

ABH ID: _____ DOB: _____ Age/Gender: _____

Member Address: _____ Member County: _____

Most recent phone number: _____ Alternative contact phone number _____

Primary Language: _____ Primary Language Assessment: _____

Transition of Care Alert:

30 Day Readmission # IP admits within past year: _____
AMA Discharge
Nursing Home Placement
Excessive ER Use # ER visits within the past year: _____
Shift Care Services Needed for Discharge (specify type): _____
Visit Nursing Needed for Discharge
Medication Reconciliation IP Stay > 30 days
Caregiver Needs (specify): _____
Lack of social supports
DME Needs: _____

Indicate any care coordination barriers:

Housing	Physical Limitations	Medical Services
Lack of Support	Transportation	Other: _____
No Phone	Financial	

Current Diagnosis Summary: _____

Currently Receiving BH Services: _____

Narrative:

Concerns/Diagnosis/Population leading to Referral:

<p>Diabetes</p> <p>Pregnancy (select type): _____</p> <p>Sickle Cell Anemia</p> <p>Domestic Abuse</p> <p>Current NICU Admission</p> <p>Post NICU Admission</p> <p>Pediatric Shift Care Referral _____</p> <p>Neonatal Abstinence Syndrome (NAS)</p> <p>Substance Abuse Coordination</p> <p>Mental Health</p> <p>Behavioral Health</p> <p>Serious Persistent Mental Illness (SPMI)</p> <p>Serious Emotional Disturbance</p> <p>CHIP BH</p> <p>Lead Coordination</p> <p>Nerve or Brain Problems</p> <p>Breathing Problems (i.e. Asthma, difficulty breathing, COPD)</p> <p>Blood Pressure Problems (HTN, Low Blood Pressure)</p> <p>Cardiac Problems (Chest Pain, History of Heart Attack, CAD, CHF, Other)</p> <p>Transplant (specify type): _____</p> <p>Infection problems (select type): _____</p> <p>CG&A Referral: _____</p> <p>Request for Par Provider (specify): _____</p>	<p>Cancer</p> <p>Child in Substitute Care</p> <p>Adult Protective Services Report</p> <p>Eating Disorder</p> <p>Children with Special Health Care Needs</p> <p>COVID-19 _____</p> <p>Kidney problems (dialysis)</p> <p>Vision Impairment</p> <p>Hearing Impairment</p> <p>Court Ordered Treatment</p> <p>Autism Spectrum Disorder</p> <p>Bone or Joint problems (Arthritis, Amputation, Chronic Pan)</p> <p>Early Intervention</p> <p>Evaluate for Recipient Restriction Program</p> <p>Tobacco Abuse</p> <p>MANNA Request/Referral</p> <p>Difficulty Navigating Health Care System</p> <p>Linkage to BH MCO/Provider</p> <p>Referral to Opioid Centers for Excellence</p> <p>Referral to SBIRT Provider</p> <p>Request MAT provider</p> <p>Enrolled on Waiver Program</p> <p>MATP Coordination</p> <p>DME Needs:</p>
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Referral Completed by: _____

Contact Phone Number: _____

Referrer Request Notification of Outcome of Referral: _____