Administrative Tools

Special Needs Case Management Referral Form

Please send all referral requests via fax to 1-877-683-7354. (For internal referrals send form to PA CM Referral Mailbox via Outlook.)
All fields must be completed for processing of this referral.

Member Name: _____ **DOB:** _____ **Referral Date:** _____

Member Phone Number: _____ **POA/Guardian Name/Phone:** _____

Member Address: _____

Insurance Plan: _____ **Member ID Number:** _____ **COB:** ☐ **Yes** ☐ **No**

Referred by: _____ **Contact Number:** _____

Concerns leading to referral (check all that apply):

☐ Diabetes	☐ Nerve or brain problems: Stroke, multiple sclerosis, spinal cord injury, epilepsy/seizures	☐ Kidney problems, like dialysis
☐ Cancer	☐ Breathing problems like asthma, difficulty breathing, COPD	☐ AMA discharge
☐ High risk pregnancy	☐ Blood pressure problems like hypertension	☐ Excessive ER use
☐ Sickle cell anemia	☐ Transplant (specify type): _____	☐ Vision impairment
☐ Domestic abuse	☐ Infection problems like: Hepatitis, HIV/AIDS or TB	☐ Children in substitute care
☐ Eating disorder	☐ Unable to navigate system on own	☐ Court ordered Tx
☐ Transition of Care (member transitioning onto/off of the plan)		☐ Heart problems like chest pain, heart attacks, congestive heart failure
☐ Mental health problems like depression, anxiety, suicidal, or alcohol or drug abuse		☐ Child w/ special needs, e.g., Autism, two or more IP admits within six
☐ Evaluate for Recipient Restriction Program		☐ Bone or joint problems like arthritis, amputation, chronic pain
☐		☐ Early intervention

Indicate any care coordination barriers:

☐ Housing	☐ No phone	☐ Transportation	☐ Medical services
☐ Lack of support	☐ Physical limitations	☐ Financial	☐ Other: _____

Current diagnosis if known: _____ ☐ Unknown

Is the member enrolled into any PA Waiver Program? (please specify) _____ ☐ N/A

Member primary language: _____

How well does the member speak English? (Only if their primary language is English) ☐ Very well ☐ Well ☐ Not well ☐ Not at all

Is the member enrolled in any Behavioral Health Services? ☐ Yes ☐ No _____

Notes: _____

_____

_____

_____

Date: _____ **Signature 1:** _____

Signature 2: _____

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