Referral to Member Care Management

Fax to – Intake Unit (1-877-243-6819)

Date of Referral: * indicates mandatory

Member Information		**Person Submitting Referral Information**	
***Name:**		***Name:**	
***Address:**		**Address:**	
***Phone :**		***Phone:**	
***DOB:**		**Fax:**	
Email:		**Primary Diagnosis**	
***Member ID#:**		**2ndary Diagnosis**	
Specifics of Referral:			
Reason For Referral:			
Clinical Information:			
Services Needed:			
****Immediate Need Identified: Y N**			
Does the member know someone from the Health Plan will be calling? Yes No			
PCP:		**Phone & Ext #:**	