Case Management Referral Form

All Lines of Business

To refer a member for case management services, please complete and return this form via a secure email or fax to:

Integrated Care Coordination / Case Management
Email: HCHHCACaseManagement@HealthChoiceAZ.com
Fax: 480-317-3358

Referral Priority: ☐ **Urgent** (0-7 Days) ☐ **Routine** (10-14 Days)

MEMBER INFORMATION

Health Choice Member ID:	Member name:	Date of Birth:
Current / Best Phone Number to Reach Member:	Best Time to Call Member:	
Referral Source (Internal, PCP Office, Hospital, Matrix):		
Person Referring:	Person Referring Contact Information:	

Case Management's goal is to promote the member's wellness, autonomy and appropriate use of service and financial resources.

REASON FOR REFERRAL / CRITERIA (Please check all that apply):

☐ **Emergency Room Visits or Hospitalizations of two (2) or more admissions in less than six months.**

☐ **Chronic Condition** (e.g. Asthma, CHF, COPD, CAD, Diabetes, HTN)

Diagnosis: ______________________________

☐ **Specialty Condition** (e.g. MS, Parkinson's Disease, ALS, Lupus, Rheumatoid Arthritis, Cystic Fibrosis, Hemophilia, Sickle Cell Disease)

Diagnosis: ______________________________

☐ **Behavioral / Mental Health Needs** (please describe):

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☐ **Non-Compliance with Treatment / Medications**

☐ **Education on diagnosis, medications and self-management.**

☐ **High Risk OB** (please describe):

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☐ **Resources for Social Needs / Financial Assistance** (please describe):

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☐ **Other** (please describe):

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