Care Management Referral Form

Please submit the completed form by fax: 1-800-520-6564 or email: mscaremanagement@telligen.com

Referral Date: _____

Referral Source: _____

Referral Source Contact Information:

Email: _____

Phone: _____

Client Information

Name: _____ Date of Birth: _____

Gender: _____ Primary Language: _____

Mailing Address: _____

Phone: _____

Medicaid Number: _____

Primary Diagnosis: _____ Secondary Diagnoses: _____

Reason For Referral

Beneficiaries with one or more of the diagnoses listed:

- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome(HIV/AIDS)
- ☐ Beneficiaries enrolled at date of delivery and during the postpartum coverage period
- ☐ Beneficiaries enrolled in the Katie Beckett category of eligibility
- ☐ Beneficiaries in their first year of life whose medical status places them at high risk for mortality and/or morbidity
- ☐ Beneficiaries who are pregnant and who are at high risk of adverse outcomes

Additional details related to the reason for referral:

_____

_____