Case Management Referral Form

Date of referral: _____ ☐ **URGENT** REFERRAL ☐ Member Expecting Outreach

Requestor Information:

Your Name: _____
Business Name: _____
Address: _____
Phone Number: _____
Relationship to Member: _____

Member Information:

Member Name: _____
Date of Birth: _____
Insurance ID: _____
Phone Number: _____
Guardian Name, if applicable: _____

Reasons for Referral (Please mark all that apply)

Utilization
- ☐ Out of Network Provider
- ☐ Frequent/Improper ER Visits
- ☐ Multiple Hospital Admissions
- ☐ Needs Related to Discharge

Treatment Adherence
- ☐ Services
- ☐ Provider Visits
- ☐ Medications
- ☐ Treatment Plan

Social Determinants
- ☐ Transportation
- ☐ Housing
- ☐ Food
- ☐ Financial Resources

Disease Management
- ☐ New Significant Diagnosis
- ☐ New Significant Medications
- ☐ Poorly/Uncontrolled Condition

Gaps in Care
- ☐ Physician
- ☐ Medical Equipment
- ☐ Medications
- ☐ Facility
- ☐ Medical Services
- ☐ Authorizations

What type of Case Management program is needed for this member?

☐ Pregnancy ☐ Mental Health ☐ Medical ☐ Not Sure

What do we need to know before we call the member? Please provide detail for the reason you are referring the member for Case Management.

Please email referrals for pregnant members to: HPMATERNITYCASEMANAGEMENT@BSWHealth.org
Please email all other referrals to: CaseManagement@BSWHealth.org
Please email referrals for Mental Health to: HPBHCaseManagement@BSWHealth.org