

Case Management Referral Form

Please submit the referral form via fax to **1-844-464-9238** or email to **SM_MODCMREF@healthybluemo.com**.

Referral date:	Is member aware of referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referred to: <input type="checkbox"/> CM <input type="checkbox"/> DM
Member name:		DOB:
DCN number:	Member's phone number:	
Member's address:		
POA guardian name:		POA guardian phone number:
Other insurance carrier:		Policy # (if known):
Name of person referred by:		Referred by contact number:

Reason for referral (check all that apply):

<input type="checkbox"/> AMA discharge	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Pervasive developmental disorders
<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Eating disorder with medical complications	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Cancer (new dx or treatment)	<input type="checkbox"/> Excessive ER use	<input type="checkbox"/> Pregnancy with serious mental illness/substance use
<input type="checkbox"/> Cardiovascular/stroke complications	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Repeated non-compliance with meds or <input type="checkbox"/> treatment plan
<input type="checkbox"/> Child with special needs — specify:	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Respiratory failure/complications
<input type="checkbox"/> Children in foster care or on foster or adoption subsidy	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Serious mental illness diagnosis
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Kidney/liver disease	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Complex medical treatment	<input type="checkbox"/> Lack of support and/or resources	<input type="checkbox"/> Substance use
<input type="checkbox"/> Complex multiple surgery	<input type="checkbox"/> Lead exposure	<input type="checkbox"/> Suicidal/homicidal ideation History of attempts:
<input type="checkbox"/> Court-ordered treatment	<input type="checkbox"/> Lack of support and/or resources	<input type="checkbox"/> TBI/seizure disorder
<input type="checkbox"/> Dementia with current complications	<input type="checkbox"/> Medical trauma/burns	<input type="checkbox"/> Transplant
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Member transitioning onto/off the plan (transition of care)	<input type="checkbox"/> Two or more IP admits within six months
<input type="checkbox"/> Domestic abuse	<input type="checkbox"/> Mental health/substance use	<input type="checkbox"/> Unable to navigate system on own

Barriers to treatment (check all that apply):

<input type="checkbox"/> Financial	<input type="checkbox"/> No phone	<input type="checkbox"/> Provider availability
<input type="checkbox"/> Housing	<input type="checkbox"/> Physical limitations	<input type="checkbox"/> Transportation
<input type="checkbox"/> Lack of support	<input type="checkbox"/> Other: (specify)	
Current diagnosis (if known):		Current medications (if known):
Important case details (if known):		
Current PCP:		PCP phone number:
Current specialist:		Specialist phone number:

<https://provider.healthybluemo.com>

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Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.