



## Health Services Referral for Case Management Request Form

<b>Provider Information</b>	
Name:	
Contact Name:	Phone Number:
NPI:	TPI:
<b>Client/Member Information</b>	
Name:	
Medicaid/CHIP ID Number:	
Phone Number:	Alternate Phone Number:
<b>Referral Because of Office Issues</b>	
<input type="checkbox"/> Treatment Plan Adherence	<input type="checkbox"/> Abuse of the Emergency Room
<input type="checkbox"/> Abuse of doctor / staff	<input type="checkbox"/> Frequently missed appointments
<input type="checkbox"/> Other:	
<b>Case Management / Health Education Needs</b>	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Childhood illness
<input type="checkbox"/> Community Resources	<input type="checkbox"/> Cardiac
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Transportation
<input type="checkbox"/> Dental	<input type="checkbox"/> Parenting
<input type="checkbox"/> Behavioral Psych Disorder	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Special Health Care Needs	<input type="checkbox"/> Exercise
<b>Prenatal – High Risk Pregnancy (This information for referral to Case Management Only)</b>	
<input type="checkbox"/> Non-Compliant with Prenatal Care	<input type="checkbox"/> Drug Use
<input type="checkbox"/> Missed Appointment	<input type="checkbox"/> Diabetes, or other Health Issue
<input type="checkbox"/> Other:	
Other Referral Comments:	
<b>Fax to 1-866-741-5650</b> <b>For Driscoll Children's Health Plan Members Only</b> <b>Referrals are also received by telephone: 1-877-222-2759 (M-F, 8 to 5 CST)</b> <b><u>Please use Pregnancy Notification Form to notify us of Pregnant Member</u></b>	