Attachment D

Care Management Referral Form- East Central Region

Please use this form to refer a Buckeye Health Plan member to the Care Management Program

Date: _____

Member Name: _____

Member's Date of Birth: _____

MMIS ID #: _____

Member Address: _____

Member Phone #: _____

Please check the reason for the referral:

□ Non Compliance to treatment plan □ Complex Medical Issues

□ High Emergency Room usage □ Multiple Hospitalizations

□ Social Service Issues □ Mental Health Issues

□ Education regarding disease management/self management skills

□ High Risk Pregnancy/Please attach Notification of Pregnancy

□ Other (explain): _____

Please use the space below to give details about the referral

Provider Name: _____

Provider Phone & Fax Number: _____

Requested by: _____

Please fax this form to: **Or you may call referrals to:**

1-866-528-9924 **1-866-246-4359**