



Complex Case Management Referral Form

Please complete the Form, attach pertinent documents and Fax to **502-379-4148** . Thank you for the referral!

Health Reason for the Referral

- ☐ Cancer, type: _____
- ☐ Transplant, type: _____
- ☐ Premature infant, ventilator dependent > 24 hours and/or weight < 1500 grams
- ☐ Long term care, identify reason: _____
- ☐ Terminal illness, identify reason: _____
- ☐ Other Catastrophic/Complex diagnosis requiring coordination of care, connection to services, coordination of benefits, identify: _____
- ☐ Compounding psychosocial factors presenting actual or potential barriers to care, identify: _____
- ☐ Non-healing wound requiring active treatment for a duration > 3 months
- ☐ Out of Network referral due to lack of access

Date: _____ Member ID: _____

Last Name: _____ First Name: _____

Date of Birth: _____

Address Street 1: _____

Address Street 2: _____

City: _____ State: _____ Zip Code: _____

Best Phone: _____ Alternate Phone: _____

Best time to call: _____

Practitioner/Facility making the referral: _____

Phone number: _____

Fax number for member impact updates if applicable: _____

Point of contact for more information: _____

Current services, if known: _____

Has the referral been discussed with the member (circle)? YES NO

What is your outcome goal for the member by making a Case Management referral?
