



# Health Choice Generations Case Management Referral

Return Response: (Check one)  Urgent (3 days)  Routine (7-10 days)

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

PCP: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

PCP Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Case Management's goal is quality and cost effectiveness of outpatient care, appropriate utilization of inpatient stays and improving customer satisfaction.**

Please check any of the following criteria:

- \_\_\_\_\_ Frequent ER visits or admissions (2 or more a month).
- \_\_\_\_\_ Diagnosed with catastrophic/chronic illness or complications requiring major changes in lifestyle, living arrangement, caregiver roles.
- \_\_\_\_\_ Behavioral/thought process changes that cause poor hygiene, poor nutrition, inappropriate decision process, poor or non-compliant with medications and/or prescribed medical treatment.
- \_\_\_\_\_ High risk OB (Please describe below).
- \_\_\_\_\_ Nonadherent behavior (Please describe below).
- \_\_\_\_\_ Suspected financial or social problems.
- \_\_\_\_\_ Suspected knowledge deficit about disease process or medication.

Why is the patient being referred to Case Management? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List interventions initiated prior to Case Management referral (e.g. DME, Home Health, CHF, Outpatient Diabetes Program, Behavioral Health, ALTCS, Etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(HCG) Person Referring: \_\_\_\_\_ Phone Ext.: \_\_\_\_\_ Date: \_\_\_\_\_

Who Called HCA about this referral: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Please return a copy of this form to  
Health Choice Generations by faxing to  
480-317-3358 or 1-800-323-9652**

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### **Case Management Only**

**Findings & follow-up notes:**