

Case Management Referral Form

All information contained on this form is strictly confidential and may become part of your patient's record.

Member information			
Member name:		Member DOB:	
Amerigroup member ID #:		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Member phone #:		Alternate phone #:	
Referring physician name:		Referral date:	
Referring physician phone #:		Fax #:	
Complex health condition(s)			
<input type="checkbox"/> Asthma	<input type="checkbox"/> High risk pregnancy		
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Hypertension		
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> HIV/AIDS		
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Major depressive disorder		
<input type="checkbox"/> Chronic obstructive pulmonary disease	<input type="checkbox"/> Substance use disorder		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other (explain in reason for referral)		
Reason for referral			
Additional comments			
Please fax form to the appropriate number below: OB case management: 1-866-249-1180 Physical health case management: 1-866-249-1185 Behavioral health case management: 1-844-664-7176			