Care Management Referral Form

All Lines of Business

To refer a member for care management services, please complete and return this form via a secure email or fax to:

Integrated Care Coordination / Care Management

Email: HCHHCACaseManagement@azblue.com

Fax: 480-317-3358

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

Care Management's goal is to promote the member's health literacy, self-management, and health outcomes.

Referral Priority: ☐ **Urgent** (0-7 Days) ☐ **Routine** (8-14 Days)

MEMBER INFORMATION

BCBSAZ Health Choice Member ID:	Member name:	Date of Birth:
Current / Best Phone Number to Reach Member:	Best Time to Call Member:	
Referral Source (Internal, PCP Office, Hospital, Vendor):		
Person Referring:	Person Referring Contact Information:	

REASON FOR REFERRAL (Please check all that apply):

☐ **Emergency Department Visits or Hospitalizations of two (2) or more admissions in less than six months.**

☐ **Chronic Condition** (e.g., CHF, COPD, CAD, Diabetes, HTN)

Diagnosis: _____

☐ **Specialty Condition** (e.g., CRS, MS, Parkinson's, Cancer, ALS, Lupus, Rheumatoid Arthritis, Cystic Fibrosis, Hemophilia, Sickle Cell Disease)

Diagnosis: _____

☐ **Behavioral / Mental Health Needs** (please describe):

_____

☐ **Non-Compliance with Treatment / Medications**

☐ **Education on diagnosis, medications, and self-management** (please describe):

_____

☐ **High-Risk OB** (please describe):

_____

☐ **Resources for SDOH/ Financial Assistance** (please describe):

_____

☐ **Other** (please describe):

_____