

Confidential

Bright Health Care Management Referral Form



Please complete this form to refer any Bright Health member to the Care Management program. This form must be shared ONLY in a private and confidential manner (as required by HIPAA) via private facsimile, encrypted email or phone call, using the contact information below.

Referral Date	Fax Number
	1-833-294-1057

Care Management Referral Reason
Write reason member is being referred for CM:

Member Information		
Member ID:		
Last Name:	First Name:	MI:
Date of Birth:	Phone:	
Representative/Guardian Name, Relationship to Member and Phone Number:		
Recommended for Outreach within 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No		Anticipated Discharge Date:

If Inpatient, please list the Facility name, Contact, Phone Number & Fax Number:

Additional Needs

Provide additional referral information in the space below.

- Community Resources/Services Identification
- Care Coordination
- Discharge Assistance
- Disease Management Need/Education
- Complex Medical/Behavioral Health Need

Additional Needs:

Referring Contact Information

Last Name:

First Name:

Relationship to Member:

Phone:

Send completed form to:

Fax# 1-833-903-1607

or

Casemanagement@brighthouseplan.com

If you have questions about this form, please call the Bright Health Care Management team anytime between 8:00 a.m. and 5:00 p.m. CST time, Monday through Friday at **1-888-658-6818**.

Fax – Confidential

To: Bright Health Plan	From:
Fax: 1-833-903-1607	Date:
Phone:	
Re: Case Management Referral Request	
Additional Message:	