

## CONFIDENTIAL - MEDICARE ADVANTAGE CARE MANAGEMENT REFERRAL FORM

*This form must be shared ONLY in a private and confidential manner  
(as required by HIPAA) via private facsimile, secure email, or U.S. Mail.*

<b>REFERRAL DATE</b>	<b>REFERRAL TYPE</b>
	<input type="checkbox"/> Behavioral Health Case Management  <input type="checkbox"/> Medical Case Management  <input type="checkbox"/> Disease Management ( <i>please identify program below</i> ) <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> CAD <input type="checkbox"/> CHF <input type="checkbox"/> COPD  <input type="checkbox"/> Multi-Chronic Care Management (MCCM)
<b>FAX PHONE #</b>	
(888) 975-9419	

MEMBER INFORMATION		
Member ID:	Last Name:	
Medicare #:	First Name:	Middle Initial:
Date of Birth (DD/MM/YYYY):	Phone #:	
Representative/ Guardian Name	Relationship to Member	Phone Number:
Recommended for Outreach within 24 hours? (Yes/ No)	Anticipated Discharge Date (DD/MM/YYYY): <small>If not known, type "unknown" or "TBD"</small>	
If Inpatient, please list the Facility name	Phone Number:	Fax Number:

PRIMARY DIAGNOSES, Rx, and TREATMENT HISTORY
Medical:
Behavioral:
Medication(s):
Psychosocial:

**PAGE 2**  
**CONFIDENTIAL - MEDICARE ADVANTAGE**  
**CARE MANAGEMENT REFERRAL FORM**

<b>REFERRAL REASON</b> (Provide reason for referral in the space below)

<b>REFERRING CONTACT INFORMATION</b>	
<b>Last Name:</b>	<b>First Name:</b>
<b>Relationship to Member:</b>	<b>Phone #:</b>

---

**If you have questions about this form, please call:**

**(844) 201-4027    8:00 am – 6:00 pm, local time, excluding federal holidays**

**This form can be faxed to (888) 975-9419.**

# Fax – Confidential

**To:**

Bright Health Plan

**From:**

**Fax:**

(888) 975-9419

**Date:**

**Phone:**

**Re:**

Care Management Referral Request

## Additional Message