bright HEALTH

Action Required

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.

REFERRAL DATE
FAX PHONE #
(888) 975-9419

REFERRAL TYPE

- ☐ Behavioral Health Case Management
- ☐ Medical Case Management
- ☐ Disease Management *(please identify program below)*
  ☐ Asthma ☐ Diabetes ☐ CAD ☐ CHF ☐ COPD
- ☐ Multi-Chronic Care Management (MCCM)

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) Yes	**Anticipated Discharge Date** (DD/MM/YYYY): If not known, type "unknown" or "TBD"	
If Inpatient, please list the Facility name	**Phone Number:**	**Fax Number:**

PRIMARY DIAGNOSES, Rx, and TREATMENT HISTORY

Medical:
Behavioral:
Medication(s):
Psychosocial:

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REFERRAL REASON (Provide reason for referral in the space below)

REFERRING CONTACT INFORMATION	
Last Name:	**First Name:**
Relationship to Member:	**Phone #:**

If you have questions about this form, please call:

(844) 201-4022 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