COMMUNITY FIRST HEALTH PLANS

Request for Care Management Services

REFERRAL				
Referral Date:	**Referral Source (Please check one):** ☐ Health Care Provider ☐ Community Agency ☐ School ☐ Health Plan ☐ Individual ☐ Other			
	Name of Referral Source (List agency/company name):			**Name of Person Making Referral:**
Phone Number for Person Making Referral: ( )	**Fax Number for Person Making Referral:** ( )			
Do you Desire Information Regarding the Status of the Referral? ☐ YES ☐ NO				
MEMBER INFORMATION				
Member Name		**DOB:**	☐ Male ☐ Female	
Medicaid #: **CFHP ID #:**	**Describe Medical/Health Condition/Risk or High-Risk Pregnancy Condition:**			
Parent/Guardian Name (if client is under 18):		**Language Preference:**		
Residential Address:		**City:**	**ZIP:**	**County:**
Phone Numbers:	**Home:**	**Work:**	**Cell:**	**Other:**
REASON for Referral/Need for case management:				
PRIORITY Status of Referral: ☐ **Urgent (needs to be contacted within 2 working days)** ☐ **Standard (needs to be contacted within 5 working days)**				

Email to chelp@cfhp.com

8/15/2022