COMMUNITY FIRST HEALTH PLANS

Request for Case 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