QualChoice® HEALTH INSURANCE

CARE MANAGEMENT REFERRAL FORM

QCARE Care Management Programs are designed to assist members with more complex acute and chronic health care needs. Members are assigned to a nurse who will assist them and their PCP/provider to access, facilitate and coordinate health services. Members appropriate for referral 1) have a complex medical or behavioral health condition, 2) receive medical care in the network, and 3) for whom QCARE services would likely reduce member risk of an adverse outcome. To request Care Management services, please complete the information below and fax this form to our QCARE office at **833.681.2495** or **833.681.2498**.

PLEASE CHECK ONE: ☐ Medical / Surgical Referral (includes adult, pediatric and OB) ☐ Behavioral Health Referral

Section I: Employee Information. Please print legibly.

Insured Name (Last, First, MI)			
Member's Qualchoice ID Number	Date of Birth	Phone Number	
Home Address	City	State	Zip

Section II: Referral Information

1. Is the member aware of this referral and does the member agree to accept a contact from a QualChoice Care Manager?
   ☐ Yes, Member is aware and agrees. ☐ No, Member is not aware that this referral is being made.

2. Referral Information
   - ☐ Disease Management (hypertension, diabetes, asthma, etc)
   - ☐ Health Coaching (smoking cessation, stress management, weight management)
   - ☐ Complex Medical Care Case Management (cancer management, multiple trauma)
   - ☐ Transplants
   - ☐ Behavioral Health or Substance Use disorder
   - ☐ Maternity/Infant/Pediatric
   - ☐ Other (explain) _____

3. Does the member need help in managing his/her treatment plan or coordinating services related to a health condition or diagnosis?
   ☐ No ☐ Yes (explain) _____

4. If Behavioral Health Referral, has the member consented to Mental Health/Substance Use Disorder services?
   ☐ No ☐ Yes

5. Please describe the support system the member has at this time?

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Section II: referral information (contd)

6. Is the member currently receiving any of the following?

- ☐ None of these
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Home Health Services
- ☐ Infusion Services
- ☐ Outpatient Therapies
- ☐ Behavioral Health/Substance Treatment
- ☐ Other (explain) _____

7. Does the member use any of the following equipment at home?

- ☐ Oxygen
- ☐ PAP/Bipap/apnea monitor
- ☐ Wheelchair, Walker
- ☐ Other Special Care Equipment

8. Does the member have any urgent needs at this time?

Member Referred to **QCare** by:	Name of Organization	Phone Number

Section III: Physician Information

Name of Member's Physician	Office Phone Number