coordinated care

MemberConnections® Provider Referral Form

Use this form to request a MemberConnections®visit to a Coordinated Care Member.

Date: _____ **Please fax to 1-866-269-9510**

Member Information:

First Name: _____ Last Name: _____
Date of Birth: _____ Member ID: _____
Address: _____ City, Zip Code: _____
Phone: _____

Provider Information:

Provider Name: _____ Phone: _____
Clinic/Agency: _____ Fax: _____
Contact for Follow-Up: _____

Please check reason for referral:

☐ Missed Appointments
1 appt for High Risk, OB, EPSDT, CPX
2 appts Other
Dates/appt type missed:
_____

☐ Medications not picked up: Date/Type
_____

☐ High Emergency Room Use

☐ Review Benefits/ Basic Community Resources

☐ Unable to Contact

☐ SafeLink Phone

Please refer to us before discharging from care for missed appts.

NOTE: Complex needs (medical, social) will be forwarded to our case management team for review. Please allow 1-2 business days. Please provide any pertinent information not mentioned above:

_____
_____
_____

A MemberConnections® Representative will make 3 outreach attempts, including a home visit, if local. This process may take up to 2 weeks. A follow-up form will be faxed with the outcome. Thank you!