Attachment E

Care Management Referral Form- Northeast Region

Please use this form to refer a Buckeye Health Plan member to the Care Management Program

Date: _____

Member Name: _____

Member's Date of Birth: _____

MMIS ID #: _____

Member Address: _____

Member Phone #: _____

Please check the reason for the referral:

Non Compliance to treatment plan	Complex Medical Issues
High Emergency Room usage	Multiple Hospitalizations
Social Service Issues	Mental Health Issues

Education regarding disease management/self management skills

High Risk Pregnancy/Please attach Notification of Pregnancy

Other (explain): _____

Please use the space below to give details about the referral

Provider Name: _____

Provider Phone & Fax Number: _____

Requested by: _____

Please fax this form to:

1-866-353-8315

Or you may call referrals to:

1-866-246-4359