EL PASO FIRST healthplans, inc.

CASE MANAGEMENT REFERRAL FORM

To: El Paso First Health Plans, Inc. **ATTN: Case Management** Phone: (915) 532-3778 ext. 1500 **Fax: 915-298-7866**	FROM: _____ **(Physician's Office Name)** OFFICE CONTACT: _____ PERSON: FAX NUMBER: _____ TELEPHONE NUMBER: _____

Member Name:	**Medicaid/CHIP ID #:**	**DOB:**

Member Contact Number:	**Member Address:**

REASON FOR REFERRAL (check all that apply and add comments when applicable):

- ☐ **HIGH RISK PREGNANCY**
- ☐ **BEHAVIORAL HEALTH**
- ☐ **ASTHMA**
- ☐ **HEART DISEASE**
- ☐ **DIABETES**
- ☐ **SPECIAL HEALTH CARE NEEDS**
  (patient 20 years of age and younger, who has a condition that is expected to last more than 12 months)
- ☐ **SOCIAL WORK**
- ☐ **OBESITY**

PRESENTING CONCERN:

- ☐ Assistance locating covered services
- ☐ Coordination of care
- ☐ Non-compliance with treatment plan
- ☐ Assistance obtaining durable medical equipment/medical supplies (i.e. nebulizer, peak flow meter)
- ☐ Patient education (i.e. symptom management, self-management strategies, diabetes education)
- ☐ Assistance accessing treatment for behavioral health diagnosis
- ☐ Social concerns, please specify concern(s): _____
- ☐ High risk pregnancy, please specify condition/concern: _____
- ☐ Access to community resources (i.e. support/advocacy groups, basic needs)