Banner Plans & Networks

Population Health Management
602-747-7799

# Care Management Referral Form

**Completed Medical Forms can be sent to:**

Fax: 480-655-2537 or Email: ***BHNPopHealthManagement@BannerHealth.com***

Please send Maternal Health or Behavioral Health referrals to:
Behavioral: ***BUHPCareMgmtBHMailbox@bannerhealth.com***
Maternal Health: ***BUHPMaternalChildHealth@bannerhealth.com***

Appropriate stabilization of **EMERGENT** medical or behavioral health concerns shall be initiated through proper emergency or crisis services channels, **BEFORE** submitting Care Management Referrals. Care Management will outreach to the member within 24 business hours for urgent referrals and 72 hours for non-urgent.

**Primary Health Plan:** Please Select

**Referral Date:** _____

| Member Information | Referral Information |
|---|---|
| Additional Insurances *(If Any)*: | Requested by: |
| _____ | _____ |
| Name: _____ | Requester Name: _____ |
| Address: _____ | Phone: _____ |
| ID# _____ DOB: _____ | Diagnosis _____ |
| Phone: _____ Language: _____ | PCP: _____ |

## Reason(s) for Care Management Request

### Medical

- ☐ General Medical Issues *(ex: Member needs help understanding their diseases, coordinating care with their doctors, etc.)*
- ☐ High or Inappropriate medical utilization *(ex: frequent ER visits, frequent PCP changes, medication management issues)*
- ☐ Post Discharge Assistance for continued care management support
- ☐ Medication Assistance *(ex: education, cost barriers, adherence, and polypharmacy)*
- ☐ Chronic condition / Newly diagnosed condition*(s) (specify below)*
- ☐ Non-adherence to PCP treatment plan, missed appointments and/or annual screening
- ☐ High Priority Transplant, HIV, Hemophilia member requesting assistance
- ☐ Interdepartmental Medical Management request for immediate assistance
- ☐ Maternal Child Health – Pregnant, Postpartum *(up to 1 year after delivery)*, Pediatric *(under age 21)*, and CRS

- ☐ Dial Into Diabetes Program – Diabetic Care Management
- ☐ Home Safety Concerns
- ☐ Advance Directive / End of Life Planning
- ☐ Community Resources *(ex: financial needs, transportation, caregiver support, support groups)*
- ☐ ALTCS ONLY – Refer to assigned CM / RN
- ☐ Banner Medicare Advantage – Fall Prevention Program
- ☐ Banner Medicare Advantage – Hypertension Program
- ☐ Banner Medicare Advantage – Depression Management Program
- ☐ Other *(specify below)*

**Behavioral**

- ☐ Routine BH referrals *(ex: Member requests advocacy for Behavioral Health or indicates need for BH assistance in some way that is not urgent or related to inpatient and/or medication)*
- ☐ Member / Family member has questions about BH services, how to access covered services, complaints, etc.
- ☐ Suicidal / Homicidal caller *(Please refer **AFTER** you follow SI/HI protocol)*
- ☐ Member requests referral for BH services *(ex: therapy, groups, etc.)*
- ☐ Mental Health needs *(ex: depression, substance abuse)*
- ☐ Urgent need for psychotropic medication
- ☐ ALTCS ONLY – Refer to assigned CM/RN
- ☐ Other *(specify below)*

**Details Relating to Reason for Referral and Additional Comments**
*(What happened? What do you want done?)*