Banner Plans & Networks

CARE MANAGEMENT REFERRAL FORM

Completed Forms can be sent to:
FAX: 480-655-2537 or EMAIL: BHNPopHealthManagement@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.

Referral Date:_____

Member	Referral Information
Primary Health Plan: Please Select	Requested By:_____
Additional Insurances *(If Any)*: _____	Requester Name:_____
Name_____	Phone:_____
Address:_____	
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
- ☐ 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: Dementia, Alzheimer's, 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?)*