



Date: _____

Care Management Request Form

Care Management/Care Coordination Follow Up

MEMBER BACKGROUND:

Member Name _____

Member ID# _____

Member Address _____

Physician Name _____

Member Phone _____

Physician Phone _____

Member Birth Date _____

Diagnosis: Diabetes COPD CHF CAD Other _____

Special Instructions: _____

REASON FOR REQUEST: INPATIENT

Admitted to Hospital

Admission Date _____

Hospital Name _____

Hospital Phone _____

Admitted to LTAC/SNF/LTC

Admission Date _____

Facility Name _____

Facility Phone _____

DIAGNOSIS: _____

Inpatient Discharge Follow Up

Discharge Date _____

Frequent ER Admission

Frequent OBS/Inpatient Stay

DIAGNOSIS: _____

REASON FOR REQUEST: OUTPATIENT

Behavioral Health Coordination Home Care Coordination Dialysis DME Coordination

Education & Adherence Monitoring for: _____ Non-Compliance of: _____

Outpatient Procedure Follow Up _____

Comments: _____

REASON FOR REQUEST: MISCELLANEOUS & SOCIAL NEEDS

Care Coordination with Multiple Specialists

Specialist Type _____

Specialist Name _____

Specialist Phone _____

Community Resources

Social/Family Support Assessment

Comments: _____

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