Trilogy
Homegrown Health Care

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

DIAGNOSIS: _____

☐ **Admitted to Hospital**

Admission Date _____

Hospital Name _____

Hospital Phone _____

☐ **Admitted to LTAC/SNF/LTC**

Admission Date _____

Facility Name _____

Facility Phone _____

☐ **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: _____

CONFIDENTIAL INFORMATION FAX TO: 414-771-1159