Oklahoma HealthCare Authority

Care Management Referral Form

Care Management Phone: (877) 252-6002 **Care Management Fax: (405) 530-3217**

Referral Date:	**Date Care Mgmt Referral Received:**
	Received by:
	Referral Source Notified of Receipt: ☐ **Yes**

Referral Information

Referral Source:
- ☐ Primary Care Provider
- ☐ Specialty Provider
- ☐ ER Department
- ☐ Caseworker/ DC Planner
- ☐ Community Agency
- ☐ Other (define):

Referral Name: **Referral Phone:**

Member Information

Member Name: Member ID:

Member DOB: Member Phone:

Contact Name: Contact Phone:

Relationship to Member: ☐ Self ☐ Family ☐ Other (Specify)

Additional information:

Reason for Referral

- ☐ Coordinate complex case
- ☐ Access primary care services
- ☐ Multiple ER visits
- ☐ Access community resources
- ☐ Education needs related to condition
- ☐ Education needs related to benefits
- ☐ Multiple inpatient admissions
- ☐ Follow-up of complex inpatient admission
- ☐ Complex discharge needs
- ☐ Poly-pharmacy
- ☐ Transplant Evaluation Notification
- ☐ Other

Description of referral reason: