



Molina Healthcare of Texas, Inc. Disease Management Referral

SECTION I (Section I to be completed by referral source):

Patient's diagnosis is a(n): Existing Diagnosis New Diagnosis

Program enrollment referral for: Diabetes Asthma COPD Hypertension
 Coronary Artery Disease Congestive Heart Failure

Date: _____ Patient Name: _____

SS#: _____ DOB: _____ Patient Phone #: _____

Patient Address: _____ Medicaid ID # _____

City: _____ State: _____ Zip: _____

PCP: _____ PCP Phone #: _____

PCP Address: _____

City: _____ State: _____ Zip: _____

Product: Medicaid Effective Date: _____

Does the member have another Case Manager? Yes No

If yes, Agency Name: _____

Name of Case Manager: _____ Phone #: _____

Hospitalizations: Yes No What dates? _____

Frequent ER usage: Yes No What dates? _____

Comorbidities: _____

Name of individual making referral: _____

Title: _____ Phone #: _____ Fax: _____

SECTION II: (To be completed by the Molina Healthcare Disease Management Program)

Received by DM: _____ Date: _____ Urgent: _____ Non-Urgent: _____

Return Attention to:
Molina Healthcare Corporate Disease Management
200 Oceangate, Suite 100, Long Beach CA 90802
FAX: (800) 642-3691 PHONE: (866) 891-2320