



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