



Molina Healthcare of Florida, 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

Date Patient Name DOB

SS# Medicaid ID # Patient Phone

Patient Address

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