Disease Management Referral

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

θ **Diagnosis** θ **New Diagnosis**

_____

θ **Diabetes** θ **Asthma**

(Referrals for other medical conditions can be made to Care Coordination/Case Management)

Date:_____ Patient Name: _____

SS#:_____DOB:_____ Patient Phone #:_____

Patient Address: _____Member Case Cert #_____

City:_____State:_____Zip:_____

PCP:_____ PCP Phone #:_____

PCP Address: _____

City:_____State:_____Zip:_____

Product: Salud! _____ Molina SCI_____ UNMSCI Cares_____
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: _____

_____

Compliance (Yes/No) Comments: _____

Name of individual making referral: _____

Title: _____ Phone #:_____Fax:_____

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

Received by HES:_____Date:_____Urgent:_____Non-Urgent:_____

Received by CM: _____Date:_____

Return Attention to:
Molina Healthcare Disease Management,
8801 Horizon Blvd, Albuquerque, NM 87113
FAX: (505) 798-7315 PHONE: (505)342-4660
Outside Albuquerque: (800) 377-9594

Revised 6/07; 01/09