Molina Healthcare of Florida, Inc.
Disease Management Referral

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

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

Program enrollment referral for: θ **Diabetes** θ **Asthma**

Date:_____ Patient Name: _____

SS#:_____DOB:_____ Patient Phone #:_____

Patient Address: _____Medicaid ID #_____

City:_____State:_____Zip:_____

PCP:_____ PCP Phone #:_____

PCP Address: _____

City:_____State:_____Zip:_____

Product: θ Medicaid Effective Date:_____

Does the member have another Case Manager? θ Yes θ No

If yes, Agency Name:_____

Name of Case Manager:_____Phone #:_____

Hospitalizations: θ Yes θ No What dates? _____

Frequent ER usage: θ Yes θ 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) 942-3691 PHONE: (866) 891-2320