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

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