Community Care COLLABORATIVE

CASE MANAGEMENT REFERRAL FORM

Please see below for submittal instructions

REFERRAL SOURCE

Referral Date: _____Referral Name: _____

Referral sources: □ Provider □ Member/Relative □ UM □ Community Agency □ Other
(Please check one)

Phone no. of referral source: _____ Fax no. of referral source: _____

MAP MEMBER INFORMATION

Member name: _____ DOB: _____ □ Male □ Female

MAP ID #:_____ Home Address: _____ Language: _____

Member home no.:_____ cell: _____ work: _____ other: _____

REASON FOR REFERRAL

Reason for Referral/need for case management:

_____
_____
_____
_____

Other diagnoses affecting Member:

Diagnosis #1:_____ Diagnosis #2:_____ Diagnosis #3:_____

Are other providers involved in care: □ No □Yes

If yes, who? _____ _____ _____

Priority status of referral:

□ Urgent: needs to be contacted within 2 working days
□ Standard: needs to be contacted within 7 working days

Please Submit Referral Form to the CCC Medical Management Department via:
Phone: 512-978-8300 or fax 512-901-9787