

Complex/High Risk Care Management Referral



Health Services Department

Date of Referral: _____

From: _____ **Department:** _____

Phone: _____ **Fax:** _____

Please return the completed form to:

**Easy Choice Health Plan
Care Management Department**

[.CaseManagement@wellcare.com](mailto:CaseManagement@wellcare.com) or by fax to 855-538-0455

The patient is being referred for Complex Care Management due to:

<input type="checkbox"/> Special Needs (D-SNP) Member	<input type="checkbox"/> Transplants or transplant listed (major organ, stem cell, bone marrow)
<input type="checkbox"/> End Stage Renal Disease (on dialysis)	<input type="checkbox"/> Cancer (requiring hospitalization but not on hospice, multiple non-chemo admits, failed chemo)
<input type="checkbox"/> Complex Behavioral Health Needs	<input type="checkbox"/> Diabetes Management
<input type="checkbox"/> Readmission within 30 days for the same diagnosis	<input type="checkbox"/> Asthma/COPD Management
<input type="checkbox"/> Traumatic Injuries (Spinal cord, multiple major fractures)	<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Multiple Admissions for the same/similar diagnoses	<input type="checkbox"/> Clinical Complex issues requiring multifaceted, high cost care
<input type="checkbox"/> Multiple Chronic Illnesses	<input type="checkbox"/> Neurological Impairment (ALS, MS, Guillain-Barre)
<input type="checkbox"/> Extensive Burns	<input type="checkbox"/> Extensive Wounds
<input type="checkbox"/> Physician Referral	<input type="checkbox"/> Patient Request

Member Name: _____ **ID number:** _____

Phone Number: _____ **Date of Birth:** _____

Physician's Name: _____ **Phone Number:** _____

Pertinent Clinical History:

Mailing Address: P.O. Box 6025 | Cypress, CA 90630

Telephone: 1-866-999-3945 | **E-mail:** .ECCaseManagement@wellcare.com

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