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 or by fax to 855-538-0455

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

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