

# Referral for Care Coordination Services

Use this form to refer MHS/NHP members to our team of social workers, nurses, and behavioral health specialists. To refer a MHS member for care coordination services, please complete this form and fax it to 1-866-671-3668.

**Attachments:** Medical records or additional information attached.

Date \_\_\_\_\_ Form completed by: Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Organization \_\_\_\_\_

MHS member being referred:

Name \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Member ID# \_\_\_\_\_ Address \_\_\_\_\_

Reason for referral (check all that apply; give detail below):

## 1. Member needs assistance to access the following MHS-covered services:

- |   |   |
|---|---|
| <input type="checkbox"/> Assessment by a case manager for complex service needs | <input type="checkbox"/> A dentist                      |
| <input type="checkbox"/> A Primary Care Physician (PCP)                         | <input type="checkbox"/> An eye doctor                  |
| <input type="checkbox"/> Medications  | <input type="checkbox"/> A behavioral health specialist |
| <input type="checkbox"/> A specialist   | <input type="checkbox"/> Home health services           |
| <input type="checkbox"/> A DME/supplies provider                                | <input type="checkbox"/> Transportation                 |
|   | <input type="checkbox"/> Other                          |

## 2. Member has these psycho-social needs:

- |  |   |
|--|---|
| <input type="checkbox"/> Food                      | <input type="checkbox"/> Abuse/violence resources                 |
| <input type="checkbox"/> Educational services      | <input type="checkbox"/> Support group resources                  |
| <input type="checkbox"/> Wellness classes/services | <input type="checkbox"/> Power of attorney/living will assistance |
| <input type="checkbox"/> Shelter/housing           | <input type="checkbox"/> Other                                    |
| <input type="checkbox"/> Household resources       |   |

## 3. Member has:

- |  |   |
|--|---|
| <input type="checkbox"/> Missed several medical appointments | <input type="checkbox"/> Frequently used the emergency room/urgent care |
|--|---|

## 4. Member is pregnant: (MHS is a certified Prenatal Care Coordination and Child Care Coordination Agency)

- |   |  |
|---|--|
| <input type="checkbox"/> Due date _____ | <input type="checkbox"/> Pregnancy complications; list below |
|---|--|

Please include comments/details here:

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MHS response by: Name \_\_\_\_\_ Phone \_\_\_\_\_

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