Respiratory Program Referral Form

To make referral, fax completed form to 800-339-0715 or call 1-800-905-6989
All member referrals will be evaluated. Enrollment criteria must be met to qualify for program admission.
(Shaded fields are required)

Referral Source

From (Name and Title):	Department/Clinic:	Referral Date:
Phone:	Fax:	

Member Information

Member Name: Member DOB: Medicaid ID:		Member Phone: Member Address:
Language Preference:	Gender: Male ☐ Female ☐	Recent Hospitalization: ☐ Yes ☐ No
Hospital Discharge Disposition or Planned Disposition: ☐ Home ☐ TCU ☐ Nursing Home ☐ Other: _____		Name of Hospital/Care Facility: Hospital Discharge Date/Anticipated Discharge Date:
Provider Name:	Provider Phone:	Provider Fax:
Is Diagnosis Confirmed by Provider? ☐ Yes ☐ No		Is Member Aware of Referral? ☐ Yes ☐ No
Reason for Referral:		

Disease Programs

Asthma ☐ **Other** ☐ (please describe) **Comments:** _____ _____ _____ _____ _____	**COPD** ☐ **Comments:** _____ _____ _____ _____ _____

MHS/NHP refers to the BadgerCare Plus and Medicaid SSI members of Managed Health Services and Network Health Plan