



Ohio East Central Region Care Management Referral Form

Please use this form to refer a Buckeye Community Health Plan member to the Care Management Program

Date: _____

Member Name: _____

Member's Date of Birth: _____

MMIS ID #: _____

Member Address: _____

Member Phone #: _____

Please check the reason for the referral:

- | | |
|--|--|
| <input type="checkbox"/> Non Compliance to treatment plan | <input type="checkbox"/> Complex Medical Issues |
| <input type="checkbox"/> High Emergency Room usage | <input type="checkbox"/> Multiple Hospitalizations |
| <input type="checkbox"/> Social Service Issues | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Education regarding disease management/self management skills | |
| <input type="checkbox"/> High Risk Pregnancy/Please attach Notification of Pregnancy | |
| <input type="checkbox"/> Other (explain): _____ | |

Please use the space below to give details about the referral

Provider Name: _____

Provider Phone & Fax Number: _____

Requested by: _____

Please fax this form to:

1-866-528-9924

Or you may call referrals to:

1-866-246-4359