BlueChoice® HealthPlan of South Carolina
Medicaid

Care Management Referral Form

To be completed by person referring to Care Management or Continuity of Care.
When complete, please fax to **1-866-387-2959**.

☐ Medicaid ☐ SCHIP ☐ Other

Member Name:		DOB:	
Member Phone Number:	- -	Certificate Number:	
Date Referred to Care Management:			
Name of Person Submitting Referral:			
Phone Number:	- -		

Reason for Care Management Referral

High Risk Obstetrics-Gestational Age *Less Than 35 Weeks*

☐ Pregnancy-induced hypertension (increase over baseline of 15 mm diastolic or 30 mm systolic>140 mm/diastolic>90 mm)
☐ Diabetes on insulin
☐ Previous preterm labor: gestational age <35 weeks for two or more pregnancies on tocolytics
☐ Confirmed psychosocial issues (domestic abuse, depression) with plans to continue pregnancy
☐ Obese with a BMI of >35
☐ Current substance abuse (include smoking) - Type:
☐ Incompetent cervix ☐ Cerclage (date done):
☐ Placenta previa/abruption
☐ Other HROB: hyperemesis with weight loss of greater than 10 lbs. from pregnancy weight
☐ Other (specify high-risk medical condition):

Transplant

☐ Type: New Referral *(please check one)*: ☐ S ☐ P

Catastrophic Conditions (ADULT AND PEDIATRIC)

☐ Catastrophic/complex diagnosis requiring coordination of care, connection to services, coordination of benefits
☐ Compounding psychosocial factors presenting actual or potential barriers to care
☐ Chronic conditions requiring:
  ☐ Three or more hospitalizations within the past 6 months
  ☐ Nonhealing wound requiring active treatment for a duration greater than 3 months
☐ Provider or member is requesting case management - Contact phone number: - -

HIV/AIDS
☐ HIV
☐ AIDS

End Stage Renal Disease
☐ Hemodialysis
☐ Peritoneal dialysis

Continuity of Care Services (because of physician contract terminations or member insurance changes)

Does the member have a need for continuation of services?

☐ Acute or chronic health care condition requiring completion of service to complete a course of treatment
☐ Pregnancy
☐ Terminal illness
☐ Surgery
☐ Newborn (birth to 36 months)
☐ Comments:

What do you think Care Management can impact with this referral?

Are medical records attached to this referral? ☐ Yes ☐ No

TO BE COMPLETED BY CARE MANAGER

☐ Care management case opened Assigned Care Manager:

☐ Care management case NOT opened (check reason below):
  ☐ No active care management needed at this time
  ☐ Member is not eligible for services

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