Care Management Referral Form For Care Coordination

MEDICA®
You belong.

Date: _____

Type of Referral:

Tobacco Cessation

Disease Management

_ Cardiac
_ Asthma
_ Diabetes

Complex Case Management

Referral From:

Name: _____
Organization: _____
Phone Number: _____
Email: _____
Fax: _____

Member Information:

*First Name: _____ *Last Name: _____ *DOB: _____
*Address 1: _____
Address 2: _____
*City: _____ *State: _____ *County: _____ *Zip: _____

*Telephone: _____ Best Time to Call: ❑ 8am-11am ❑ 2pm-4pm ❑ 11am-2pm ❑ 4pm-6pm

*Member ID#: _____
*Medica Product: _____

*Primary Language:
❑ English ❑ Somali
❑ Hmong ❑ Spanish
❑ Russian ❑ Other: _____

***Reason for Referral:**

Include helpful things to know about member (e.g. cognitive, behavioral or socioeconomic factors)

Send form via secure email to:

CareSupport@medica.com

Or fax to: 1-952-992-3589

Member eligibility will be determined in 4-6 business days. Member will receive a call if eligible for program.

**Indicates required field*