Maryland | Medicaid

Case Management Referral Form (External)

This referral will be screened for case management needs. Please provide as much information as possible.

☐ Adult (21+) ☐ Pediatric (< 21) ☐ OB ☐ Special needs

Member information			
Referral date:			
Member name:		**Date of birth:**	
Parent/guardian name (for minor):		**Member ID:**	
Member phone #:	**Member consent to use phone #:** ☐ Yes ☐ No		
Name of person submitting referral:			
Referral source:	☐ Health department (county): ☐ Hospital (facility):		
	☐ Provider (practice):		
	☐ Member/caregiver ☐ Other:		
Referral source phone #:		**Referral source email:**	

Reason for referral
Why is the member being referred to case management? Select all that apply:
☐ Chronic or newly diagnosed complex condition(s): ☐ Asthma ☐ Cancer ☐ Diabetes ☐ HIV ☐ Hypertension ☐ Pregnancy ☐ Sickle cell ☐ Other: _____
☐ Coordination of care needed (such as after recent hospitalization, for home care, skilled nursing, DME, and/or medication access)
☐ Frequent hospitalization or ER use (three or more visits in six months)
☐ Non-adherence with medication and/or plan of care
☐ Severe impairment or immobility (for example, use of wheelchair/walker, para/quadriplegia, amputation, etc.)
☐ Other

Additional notes
Specific reason for referral, actions taken to assist member, etc.

Submit completed forms by email at CM_MD_Referrals@Wellpoint.com or fax: at **877-855-7558**. You can also call Member Services at **833-707-0867** or Provider Services at **833-707-0868**.

https://provider.wellpoint.com/md/