Case Management Referral Form

Date Requested:_____ **Member ID #:**_____

Member Name:_____ **Member DOB:**_____

Member Contact Information:_____

_____

Referral Timeframe: ☐ **Routine** ☐ **STAT**

Reason for Referral:_____

_____

_____

_____

_____

Healthcare Plan Contact Information

Contact Name:_____ **Title:**_____

Preferred method of contact: ☐ **Telephone** ☐ **Secure Email**

Contact Telephone Number:_____

Contact Email Address:_____

Delivery Instructions

Please fax this completed form to 305.514.5311, Attention: Integrated Care Coordination Department

OR

Secure Email to: carecoordination@cariskpartners.com