Carisk® BEHAVIORAL HEALTH

COMPLEX CASE MANAGEMENT REFERRAL FORM

Date of Referral: _____ Referral Timeframe: ☐ Routine ☐ Stat

Member Name: _____ Member ID: _____

Member Date of Birth: _____ Member Contact Info: _____

Referral Source: ☐ HP ☐ PCP ☐ Specialist ☐ Agency ☐ Emergency Dept ☐ Other

Referral Contact Name: _____ Referral Contact #: _____

Referral Contact Fax: _____ Email: _____

Reason for Referral:

_____

_____

_____

Member Diagnosis (If available): _____

(Code and Describe SA diagnosis when applicable. SA diagnosis must also be included on claim)

Member Treatment Hx: ☐ Compliant ☐ Non-Compliant Medication

If Non-compliant, provide explanation: _____

_____

_____

Please fax the form to 305-514-5311 Attention: Integrated Care Coordination Department or Email to: careadvocacy@cariskpartners.com

By signing this document I consent to giving Carisk Behavioral Health permission to communicate with and/or release the information contained on this form (may include HIV Status or Substance Abuse, if applicable) to my Health Plan, PCP and other clinicians involved in the coordination of my care until I am no longer a Carisk Behavioral Health member. (This consent/release includes my Support System Contact ☐ Yes ☐ No). You may revoke this consent at any time by notifying Carisk Behavioral Health in writing at careadvocacy@cariskpartners.com.

_____ _____

Member Signature or Legal Guardian Date

For Office Use Only:

Date Received: _____ Disposition: ☐ Referred to CCM ☐ Other

Explain: _____