IEHP Covered Care Management Referral

Date:

Member Name: **Member ID:** **Member DOB (DD/MM/YYYY):**

Best point of contact (please check one): ☐ Member ☐ Caregiver/Family Member

Contact's name:

Contact's phone number:

Was the Member informed of the referral (Y/N)? ☐ Yes ☐ No

Reason for Referral:

Please describe the primary reason for this referral and any specific challenges or needs the Member is facing that warrant care coordination and complex case management:

Additional support needed with:

☐ Diagnoses/Conditions ☐ Recent Hospitalization ☐ Recent Specialist Consultations

Social Determinants of Health:

☐ Housing Resources ☐ Food Resources ☐ Transportation Resources ☐ Social Supports Resources

Behavioral Health:

☐ Behavioral Health Support Resources

Referring Provider:

Name: **NPI:**

Phone number:

Email:

Please attach all applicable documentation regarding the Member's reason for referral

Return this completed form via secure email to CMReferralTeam@iehp.org with the applicable documents.
(Allow up to five business days for referral processing and response.)