Aetna Better Health® of Michigan
28588 Northwestern Hwy
Southfield, MI 48034
1-855-676-5772

Case Management Referral Form

Member Name:	**DOB:** Click here to enter a date.	**Referral Date:** Click here to enter a date.
Insurance Plan: Click here to enter text.	**Member ID Number:** Click here to enter text.	**COB:** ☐ Yes ☐ No
Member's Current Phone Number: Click here to enter text.	**POA/Guardian Name & Phone Number:** Click here to enter text.	**Member aware of Referral?** ☐ Yes ☐ No

Referred by: Click here to enter text.

☐ BH UM ☐ MS
☐ BH CM ☐ PA
☐ Member Advocate ☐ Medical UM
☐ Medical CM ☐Provider
☐ Medical Director ☐ Other

Referral to: Click here to enter text.

☐ Adult Team – CM
☐ Peds Team – CM
☐ Perinatal CM
☐ Disease

Concerns leading to referral: (check all that apply)

☐Transplants
☐Chronic Pain
☐Cancer (new Dx or treatment)
☐Complex/multiple surgery
☐HIV/AIDS
☐Lead Exposure
☐Sickle Cell Anemia
☐Children in Foster Care or in Foster Adoption Subsidy
☐Suicidal/Homicidal Ideation/Hx of
☐Unable to Navigate System on own
☐Court Ordered Treatment
☐Pregnancy with Serious Mental Illness/Substance Abuse
☐Kidney/liver medical complications
☐Cardiovascular/Stroke complications
☐Respiratory failure/complications
☐Dementia with current complications
☐Pregnancy
☐Diabetic
☐Child w/ Special needs – Specify: Click here to enter text.
☐Anxiety Disorders
☐Member transitioning onto/off of the plan (transition of care)
☐Serious Mentally Ill Diagnosis
☐Lack of Support and/or Resources
☐Eating Disorder
☐AMA Discharge
☐TBI/Seizure disorder
☐Eating Disorder with medical complications
☐Complex Medical Treatment
☐Medical trauma/burns
☐Hepatitis
☐Pervasive Developmental Disorders
☐Pervasive Developmental Disorders
☐Domestic Abuse
☐Substance Abuse
☐Mental Health/Substance Abuse
☐Repeated non-compliance with Meds or Tx Pain
☐Excessive ER use
☐2 or more IP admits within 6 months
☐Postpartum Depression

Indicate any treatment barriers: ☐Housing ☐Transportation

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	☐Provider availability ☐No Phone ☐Lack of Support	☐Physical Limitations ☐Financial ☐Other
Current Diagnosis if known: Click here to enter text.		
Current Medications if known: Click here to enter text.		
Important case details: Click here to enter text.		
Discharge Plan if Inpatient: Click here to enter text.		
Current PCP & Phone Number: Click here to enter text.		
Current Specialists & Phone Number: Click here to enter text.		
Referral: ☐ Accepted ☐Denied		
Date: Click here to enter a date.	**CM Assigned:** Click here to enter text.	
Decision & Date of Notification to Referral Source:	Click here to enter a date. Click here to enter text.	