



AETNA BETTER HEALTH®

Special needs case management referral form

Please send all referral requests via fax to 1-877-683-7354
(For internal referrals send form to PA CM Referral Mailbox via Outlook)
All fields must be completed for processing of this referral

Member Name: _____ DOB: _____ Referral Date: _____

Member Phone Number: _____ POA/Guardian Name/Phone: _____

Member Address: _____

Insurance Plan: _____ Member ID Number: _____ COB: Yes No

Referred by: _____ Contact Number: _____

Concerns leading to referral (check all that apply):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nerve or brain problems: Stroke, Multiple Sclerosis, Spinal Cord Injury, Epilepsy/Seizures	<input type="checkbox"/> Kidney problems like dialysis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Breathing problems like asthma, difficulty breathing, COPD	<input type="checkbox"/> AMA Discharge
<input type="checkbox"/> High Risk Pregnancy	<input type="checkbox"/> Blood Pressure problems like hypertension	<input type="checkbox"/> Excessive ER use
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Transplant (specify type): _____	<input type="checkbox"/> Vision Impairment
<input type="checkbox"/> Domestic Abuse	<input type="checkbox"/> Infection problems like: Hepatitis, HIV/AIDS or TB	<input type="checkbox"/> Children in Substitute Care
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Unable to Navigate System on own	<input type="checkbox"/> Court ordered Tx
<input type="checkbox"/> Transition of Care (member transitioning onto/off of the plan)	<input type="checkbox"/> Heart problems like chest pain, heart attacks, Congestive Heart Failure	
<input type="checkbox"/> Mental health problems like depression, anxiety, suicidal, or alcohol or drug abuse	<input type="checkbox"/> Child w/ special needs, e. g ., Autism Two or more IP admits within six	
<input type="checkbox"/> Evaluate for Recipient Restriction Program	<input type="checkbox"/> Bone or joint problems like arthritis, amputation, chronic pain	
<input type="checkbox"/>	<input type="checkbox"/> Early Intervention	

Indicate any care coordination barriers:

<input type="checkbox"/> Housing	<input type="checkbox"/> No Phone	<input type="checkbox"/> Transportation	<input type="checkbox"/> Medical Services
<input type="checkbox"/> Lack of Support	<input type="checkbox"/> Physical Limitations	<input type="checkbox"/> Financial	<input type="checkbox"/> Other: _____

Current Diagnosis if known: _____ Unknown

Is the member enrolled into any PA Waiver Program? (please specify) _____ Non-Applicable

Member primary language: _____

How well does the member speak English? (Only if their primary language is English)
 Very Well Well Not Well Not At All

Is the member enrolled in any Behavioral Health Services? Yes No _____

Notes: _____

Date: _____ Signature 1: _____ Signature 2: _____