Aetna Better Health® of Michigan
1333 Gratiot Avenue, Ste 400
Detroit, MI 48207
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 ☐ BH CM ☐ Member Advocate ☐ Medical CM ☐ Medical Director	☐ MS ☐ PA ☐ Medical UM ☐Provider ☐ 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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<table>
<tr><td></td><td colspan="2">☐Provider availability
☐No Phone
☐Lack of Support</td><td>☐Physical Limitations
☐Financial
☐Other</td></tr>
<tr><td colspan="4">Current Diagnosis if known: Click here to enter text.</td></tr>
<tr><td colspan="4">Current Medications if known: Click here to enter text.</td></tr>
<tr><td colspan="4">Important case details: Click here to enter text.</td></tr>
<tr><td colspan="4">Discharge Plan if Inpatient: Click here to enter text.</td></tr>
<tr><td colspan="4">Current PCP & Phone Number: Click here to enter text.</td></tr>
<tr><td colspan="4">Current Specialists & Phone Number: Click here to enter text.</td></tr>
<tr><td colspan="4">Referral: ☐ Accepted ☐Denied</td></tr>
<tr><td>Date: Click here to enter a date.</td><td colspan="3">CM Assigned: Click here to enter text.</td></tr>
<tr><td>Decision & Date of Notification to Referral Source:</td><td colspan="3">Click here to enter a date.
Click here to enter text.</td></tr>
</table>