Aetna Better Health® of Kentucky
9900 Corporate Campus Drive, Suite 1000
Louisville, KY 40223

CASE MANAGEMENT REFERRAL FORM

Patient Name: _____ **DOB:** _____ **Referral Date:** _____

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

Member's current Phone Number _____ **POA/Guardian Name/Phone** _____

Member aware of Referral ☐ YES ☐ NO

Referred by: **[Name(s) of referral source]** _____

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

Referral to: **[Names(s) of referred to]** _____

☐ Adult Team - CM ☐ Peds Team - CM ☐ Perinatal CM ☐ Disease Management
☐ Lock In

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 on foster or adoption subsidy
☐ Cardiovascular/Stroke complications
☐ Respiratory failure/complications
☐ Dementia with current complications
☐ Pregnancy
☐ Diabetic
☐ Child w/ special needs – specify _____
☐ Anxiety Disorders
☐ Member transitioning onto/off of the plan (transition of care)
☐ Kidney/liver medical complications
☐ TBI/Seizure disorder
☐ Eating disorder with medical complications
☐ Complex medical treatment
☐ Medical trauma/burns
☐ Hepatitis
☐ Pervasive Developmental Disorders
☐ Domestic Abuse

☐ Suicidal/Homicidal ideation/Hx of attempts ☐ Serious Mentally Ill Diagnosis ☐ Substance Abuse ☐ Mental Health/Substance Abuse
☐ Unable to Navigate System on own ☐ Lack of support and/or Resources ☐ Repeated non-compliance with Meds or Tx Plan
☐ Court Ordered Tx ☐ Eating Disorder ☐ AMA Discharge ☐ 2 or more IP admits within 6 months ☐ Excessive ER use
☐ Pregnancy with Serious Mental Illness/Substance Abuse ☐ Postpartum Depression

Indicate any treatment barriers:

☐ Housing ☐ No Phone ☐ Transportation ☐ Financial
☐ Provider availability ☐ Lack of Support ☐ Physical Limitations ☐ Other

Current Diagnosis if known: _____

Current Medications if known: _____

Important case details: _____

Discharge Plan if Inpatient: _____

_____

_____

Current PCP/Phone Number: _____ **Current Specialist/Phone Number:** _____

Referral: ☐ Accepted ☐ Denied

Date and CM Assigned: _____

Decision and Date of Notification to Referral Source _____