# **Case Management Referral** Form

***Please use this form to refer a Louisiana Healthcare Connections member to our Case Management team for a follow-up phone call.***

*For questions, please contact Provider Services at **1-866-595-8133**.*

***Required Field**

Date *(mm/dd/yyyy)** _____

## Member's Information

First Name* _____ Last Name* _____

Medicaid ID # _____ Date of Birth *(mm/dd/yyyy)* _____

Address *(Line 1)* _____ Address *(Line 2)* _____

City _____ State _____

Zip _____ Phone* _____

## Facility Information

Group/Facility Name _____ Parish of Facility Location _____

## Provider Point of Contact

First Name* _____ Last Name* _____

Phone* _____ Email* _____

Fax _____

Provider Preferred Method of Contact* ☐ Phone ☐ Email ☐ Fax

Reason for Referral *(Select all that apply.)**

☐ Integrated Behavioral Health ☐ HIV/AIDS ☐ Hemophilia ☐ EPSDT ☐ Personal Care Services (PCS)

☐ Post Hospitalization ☐ ED Utilization ☐ Sickle Cell ☐ Hospice ☐ Obesity

Please provide any additional considerations regarding your referral for the Case Management team.

_____

_____

louisiana healthcare connections™

**Fax completed form to:**
**1-877-668-2079**