PASSPORT HEALTH PLAN

CARE COORDINATION REQUEST FORM

Members Name:	Passport ID#:
Address:	D.O.B.:
Phone #:	

Indicators for referral: (check all that apply)

- ❑ Children in/or receiving Foster Care or adoption assistance that are medically fragile or needing care coordination
- ❑ Blind/Disabled Children under the age of 19 and related populations eligible for SSI needing care coordination
- ❑ Adults over the age of 65 needing care coordination
- ❑ Individuals with chronic physical health illnesses and complicated medication or treatment regime
- ❑ Individuals with chronic physical health illnesses and noncompliance with Treatment Plan
- ❑ Needing Resource assistance
- ❑ Homeless
- ❑ Request by member, parent, or legal guardian
- ❑ A pattern of inappropriate use of medical, surgical, trauma, urgent care or ER services
- ❑ Frequent hospitalizations required
- ❑ High risk populations such as but not limited to: HIV, severe or chronic renal/heart/lung disease, sickle cell, cancer, uncontrolled HTN, transplants
- ❑ Member with a diagnosis of Asthma, COPD, CHF, Diabetes, or Obesity with complicated regime or noncompliance for referral to Disease Management
- ❑ Identified high risk pregnancy for referral to Mommy Steps
- ❑ Individuals with chronic behavioral health illnesses needing care coordination for referral to Beacon
- ❑ Other: _____

Please refer even if you are unsure

Referral Notes:

Physician Name:
Address:
Phone #:

Please send completed form to:
Care Coordination Department
1-877-903-0082 (phone)
502-585-7997 (fax)