

Case / Disease Management Referral Form

Our Case Management and Disease Management programs include a set of processes that integrate utilization management, discharge planning, disease state management, advocacy, and education and risk management. Please complete this Referral form and fax it to (414) 266-1715.

Section 1 – Referral Source	e							
Name of Organization:			Contact Person Name:					
Street Address:								
City:				State:			Zip:	
Phone Number:				Fax Number:				
Section 2 – Member Inform	mation							
Name (First, M.I, Last):				Member ID:				
Parent / Legal Guardian / Caregiver Name:				Relationship:				
Street Address:								
City:				State:			Zip:	
Phone Number:				Email Ac	ldress:			
Section 3 – Reason for Referral								
When would you like us to contact member about this referral?			☐ Immediately ☐ Within one week ☐ Other:					
Is member aware of the referral?			Yes No					
Education and Support Referral For: (please check all that apply):								
Area of trauma: Level of impairmen Number of days me hospitalized related more days): Pediatric Member 2 or more inpatient	t:ember was d to trauma injury (6	or		Level of Polypho 15 or mo	f injury: f impair stroke: impair armacy ore pres	ment:	edicat	ions:
	e situations which re nedical condition a				ices (I.	z. munipie	UNCO	mrolled Chronic



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If you have additional questions, please call 414-266-3173

Chorus Community Health Plans complies with Federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability or sex. Si no habla inglés, se programarán servicios de idiomas en forma gratuita. Llame al 1-800-482-8010 (TTY: 7-1-1). Yog hais tias koj tsis txawj hais lus Askiv, peb yuav teem sij hawm muab kev pab txhais lus pub dawb rau koj. Hu rau 1-800-482-8010 (TTY: TTY: 7-1-1).