Complex Case Management Referral Form

Product:		
Patient Information		
Patient Name:	Date of Birth:	UCare ID#:
Mailing Address:	County:	Phone:
Member speaks: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other:		Interpreter Needed: ☐ Yes ☐ No
Referral Source		
Name of person referring:		Phone:
Diagnosis:		
Date and Location of most recent hospitalization (if appropriate):		Do you want to be contacted regarding this referral? ☐ Yes ☐ No
Provider Information (if known)		
Primary Care Provider/Title:	Phone:	Fax:
Primary Care Clinic:	Phone:	Fax:
Power Of Attorney/ Authorized Representative:	Phone:	
Relationship to Patient:	Consent Form Needed? ☐ Yes ☐ No ☐ Unknown	
Reason for Referral		
Reason for Referral/Diagnosis:		

*Attach any supporting documentation that maybe helpful in processing this referral for case management.

Fax to UCare at: 612-884-2284