Behavioral Health Case Management Referral Form

Return via secure email to: BHTexas.ICM@carelon.com

Maternal Mental Health Referral: ☐Yes

Referral Information					
Referral Source:		Referral Phone:		Date:	
Referral Email:		Member in Medical Case Mgmt: ☐Yes ☐No			
Medical Case Mgr *Name/Email*:					

Member Information					
Member Name:		DOB:		Member ID:	
Address:				Gender:	☐M ☐F
Responsible Party (legal guardian name):		Member Phone:			
Language spoken at home/cultural issues:		Legal Status/Issues:			
Health Plan:		Type of Coverage: ☐Medicaid ☐ CHIP ☐HIM/Commercial			

Time Frame re: Follow-Up: ☐Routine (within 7 days) ☐Urgent (24-48 hours)

Was the member informed they would be referred and contacted by Carelon Case Management Staff? ☐ Yes ☐No
If No, list reason:

Detailed Reason for Referral (note any special needs, including any dual diagnosis issues and/or urgency details): Name

Indicate Agency or Facility Contacts:		
Facility/Agency Name	Contact Person	Phone#

Behavioral Health Diagnosis (Refer to DSM V):	
DSM – 5	ICD – 10
Primary Diagnosis:	
Additional BH/SA Diagnoses:	

Medical Diagnosis (Refer to ICD-10)	
DSM – 5	ICD – 10
Primary Diagnosis:	
Additional BH/SA Diagnoses:	