

IEHP Covered Care Management Referral

Best point of contact (please check one): Member Caregiver/Family Member Contact's name: Contact's phone number: Was the Member informed of the referral (Y/N)? Yes No Reason for Referral: Please describe the primary reason for this referral and any specific challenges or needs the Member is facing that warrant care coordination and complex case management: Additional support needed with: Diagnoses/Conditions Recent Hospitalization Recent Specialist Consultations Social Determinants of Health: Housing Resources Food Resources Transportation Resources Social Supports Resources Behavioral Health: Behavioral Health Support Resources Referring Provider:	Date:				
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Behavioral Health: Behavioral Health Support Resources Referring Provider:	Social Determinants of Health:				
Behavioral Health Support Resources Referring Provider:	Housing Resources Food R	Resources Tr	ansportation Resou	rces Social Supports Resources	
Referring Provider:	Behavioral Health:				
	Behavioral Health Support Resourc	es			
Name: NPI:	Referring Provider:				
	Name:	١	IPI:		
Phone number:	Phone number:				
Email:	Email:				

Please attach all applicable documentation regarding the Member's reason for referral

Return this completed form via secure email to CMReferralTeam@iehp.org with the applicable documents. (Allow up to five business days for referral processing and response.)