

HealthPlus of Michigan
Case Management Referral Form
GFR Phone: (810)230.2029 Fax: (810)230.2002
TCR Phone: (989)797.4043 Fax: (989)799.8494

Member Name: _____ HPM ID number _____

Parents name if minor: _____ Telephone#: _____

Current Address: _____

PCP _____ PPG _____ Referral Source: _____

LOB: Medicaid _____ Comm _____ TPA _____ M+C _____ Medicare Supp _____ CHP _____

Referred to: Behavioral _____ Medical _____ Social Work _____

Desired follow-up date from CM: ___/___/___ Desired detail of follow-up _____

The date and time of your last contact with the member: _____ am / pm ___/___/___

Is member aware of this referral: Yes _____ No _____

Referrals made to other departments: _____

ER issues: Yes _____ No _____ Diagnosis: _____

Specific request: (what you would like the UCM CM to do?) _____

What prompted this referral? _____

Identify person(s) involved w/case and telephone numbers: _____

Other pertinent Information: _____

Requestor's Name : _____ Date: _____

Please attach a copy of your Plan of Care, Assessment, Advocate Referral, Prior Authorization Form, etc.

Follow up information

CM Status: Accept _____ Declined _____ Monitor _____

Description of Contact: _____

Case Manager Signature _____ Date: _____

Returned to _____ Date: _____