Care/Case/Disease Management Request

Referring Practitioner Information	
Date of Request	
Referring Practitioner	
Office Contact (if other than practitioner)	
Contact Phone #	
Office Fax #	
Contact Email Address	
Preferred method of contact: ☐ Phone ☐ Email ☐ Fax ☐ Correspondence	

Patient Information	
Patient Name	
Patient's Parent or Guardian (if applicable)	
Patient's Medicaid ID (RID) **#**	
Patient's Date of Birth	
Primary Contact Phone #	
Alternate Contact Phone #	

Reason for Referral (check all that apply)

- ☐ Medical Case Management
- ☐ Pregnancy Case Management
- ☐ Behavioral Health Case Management
- ☐ Member**Connections**® Support
- ☐ Social Services
- ☐ Substance Abuse Counseling
- ☐ Other:_____
- ☐ Child with Special Healthcare Needs
- ☐ Disease Management
- ☐ Future Appointment Scheduling/Reminder
- ☐ Restricted Card Program Compliance Assistance
- ☐ Smoking Cessation
- ☐ Transportation Assistance

Detailed request (diagnosis, treatment plan, recommendations, needed assistance):

Please send completed form with any attached additional information to MHS Case Management at:
Email: casemanagement@mhsindiana.com
Fax: 1-866-694-3653

If you have questions, please contact an MHS Case Manager at 1-877-647-4848.

This form may not be used for prior authorization/pre-certification purposes.