
PROVIDER BULLETIN

~ Referrals for Case Management ~

Please see the attached case management referral form.

Criteria for case management referral:

MEDICAL CONDITIONS

****Must have 2 or more of these Medical Conditions AND 1 High Risk criteria OR 1 of these Medical Conditions with 2 High Risk Criteria)**

- CHF (Stage 3+4 /C+D) or Ejection Fraction <35%)
- COPD w/all of the following: O2 Dependent, on Steroids & Inhaler, Restricted ADLs & multiple ER visits in 6 month period
- CVA with stroke prevention therapy
- Dementia w/comorbidities and Dependent for ADLs.
- Diabetes Uncontrolled or HA1C > 12
- End Stage Aids
- Multiple Wound Ulcers
- New onset of paralysis, paraplegia or Quadriplegia (diagnosed within 90 days)

HIGH RISK CRITERIA

****Must have 1 High Risk criteria w/ 2 or more Medical Conditions above or 2 High Risk criteria with at least 1 Medical Condition above)**

- Poor social support
- Poor functional status
- Poor nutritional status
- Continued and documented non-compliance
- More than 2 hospitalizations or more than 3 ER Visits within last 6 months

Please also include all recent progress notes, medications, pertinent labs and imaging studies.

Please fax the completed form and progress notes to: 1-818-534-5443.
For questions about case management, please call 1-800-874-2091 and ask for case management.

This case management referral form may be found on our website: www.preferredipa.com

If you have any questions, please contact Provider Relations at (800) 536-2867 Ext. 562.

Phone: 800-536-2867 Fax: 818-265-0801
www.preferredipa.com

Fax Referral Request to: (818) 534-5443

CASE MANAGEMENT REFERRAL CRITERIA MET (Select one)

- Patient with 2 or more medical conditions listed below AND 1 High Risk Criteria below
- Patient with 1 poorly controlled medical conditions below AND 2 High Risk Criteria below

PLEASE INCLUDE ALL RECENT PROGRESS NOTES, MEDICATIONS, PERTINENT LABS AND IMAGING STUDIES.

Patient Name	Male <input type="checkbox"/>	Female <input type="checkbox"/>	DOB	Age
Address	City		Zip	
Phone No:	Member Number & Health Plan			
Family/Caregiver Name	Relationship		Phone	
PCP Name / Completed by:	MD Signature:		Phone	

MEDICAL CONDITIONS

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HIGH RISK CRITERIA

****Must have 1 High Risk criteria w/ 2 or more Medical Conditions above or 2 High Risk criteria with at least 1 Medical Condition above)**

- Poor Social Support (please provide explanation below)

- Poor Functional Status (please provide explanation below)

- Poor Nutritional Status (please provide explanation below)

- > Non-Compliance (Defined as: patient having multiple PCP visits once every month for 6 month period and member continues to be non-compliant). Please provide all PCP office visit dates below.

Visit 1 _____ Visit 2 _____ Visit 3 _____ Visit 4 _____ Visit 5 _____ Visit 6 _____

- > 2 Hospitalizations or > 3 ER visits in previous 6 months