Medical Case Management Referral

Note: ***The initial member outreach will be initiated within three (3) business days of the member being identified for care management.***

Date: _____ Referral Taken By: _____ Department: _____

Please send the Mercy Care referral form by faxing to 602-431-7159

Accept	*Decline*	*Phone Intervention*	*Supervisor Initials and Due Date*

Member Name: _____ ID#: _____ BU: _____

Parent/Guardian: _____ DOB: _____ Rate Code:_____

Address: _____ Age: _____

City, Zip: _____ Eligibility Date: _____

Phone: _____ Message Phone: _____ MCP Internal #: _____

CURRENT LOCATION OF MEMBER: _____ TPL/COB ID#: _____

Current Address: _____ Policy Name: _____

Current Phone: _____ Policy #: _____

Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Person Making Referral:_____ Dept. Phone: _____

**Diagnosis: _____

Description of Problem:

_____

_____

_____

_____