Aetna Better Health® of Maryland
509 Progress Drive, Suite 117
Linthicum, MD 21090
1-866-827-2710

CASE MANAGEMENT REFERRAL FORM

Patient Name: _____ **DOB:** _____ **Referral Date:** _____

Insurance Plan: _____ **Member ID Number:** _____ **COB:** ☐ **Yes** ☐ **No**

Member's current Phone Number _____ **POA/Guardian Name/Phone** _____

Member aware of Referral ☐ YES ☐ NO

Referred by: **[Name(s) of referral source]** _____

☐ MS ☐ PA ☐ Medical Director ☐ Member ☐ Provider ☐ BH UM ☐ Medical UM ☐ Medical CM ☐ BH CM ☐ Other

Referral to: **[Names(s) of referred to- check below]** _____

☐ Adult Team - CM ☐ Peds Team - CM ☐ Perinatal CM ☐ DM

Referral From: **[Names(s) of referred from in UM:** _____

Concerns leading to referral: (check all that apply)

- ☐ AMA Discharge
- ☐ Anxiety Disorder
- ☐ Cancer (new Dx or treatment
- ☐ Cardiovascular/stroke/HTN complications
- ☐ Children in Foster Care or on foster adoption subsidy
- ☐ Children w/special needs-specify
- ☐ Chronic Pain
- ☐ Complex Medical Tx
- ☐ Court Ordered Tx
- ☐ Dementia w/ current complications
- ☐ Diabetes
- ☐ Domestic abuse
- ☐ Eating disorders
- ☐ Eating disorders w/complications
- ☐ Excessive ER use
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney/Liver medical complications
- ☐ Lead exposure
- ☐ Medical trauma/burns
- ☐ Mental health/Substance Abuse
- ☐ Pervasive Developmental Disorders
- ☐ Pregnancy
- ☐ Pregnancy w/serious mental illness/substance abuse
- ☐ Postpartum depression
- ☐ Respiratory failure/complications
- ☐ Serious Mental Illness diagnosis
- ☐ Sickle cell anemia
- ☐ Substance abuse
- ☐ Suicidal/Homicidial ideation/ hx of attempts
- ☐ TBI/Seizure disorder
- ☐ Transplant
- ☐ 2 or more IP admits within 6 months
- ☐ *Check this box and write in concern not listed

Indicate any treatment barriers:

- ☐ Financial
- ☐ Housing
- ☐ Lack of Support
- ☐ Lack of Resources
- ☐ No Phone
- ☐ Other
- ☐ Physical Limitations
- ☐ Provider availability
- ☐ Repeated noncompliance w/meds or tx plan
- ☐ Transportation
- ☐ Transition of member on/off plan
- ☐ Unable to navigate system on own

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Current Diagnosis if known: _____
Current Medications if known: _____
Important case details: _____

Discharge Plan if Inpatient: (please indicated anticipated d/c date if patient remains in the hospital at time of referral) _____

_____

_____

Current PCP/Phone Number: _____ **Current Specialist/Phone Number:** _____

Hospital D/C Contact Number: _____

Please fax to: 959-282-8012 or Send via Secured email to:AetnaBetterHealthMDCM@AETNA.com

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CM STAFF COMPETE BELOW:

Referral: ☐ Accepted ☐ Denied

Date and CM Assigned: _____

Decision and Date of Notification to Referral Source_____

RESET