



ST. JOHN'S
MEDICAL MANAGEMENT
SERVICES

CONFIDENTIAL

**ST. JOHN'S HEALTH PLANS MEDICAL MANAGEMENT
 CARE MANAGEMENT REFERRAL FORM**

Please fax completed form to (417) 820-7866 or 800-863-8040

For questions call (417)820-8880 or 1-800-662-9962

PATIENT INFORMATION

 Patient Last Name Patient First Name M.I. Date of Birth

 Subscriber/Member ID Number Diagnosis

- Premier Premier Plus Bass Pro PGP Demonstration Project
 Missouri Consolidated General Electric

REFERRAL INFORMATION

 Referring Physician Last Name Physician First name M.I. (_____) Physician Telephone Number

SERVICE BEING REQUESTED

- Case Management (Care coordination) Disease Management (Health Coach)

REASON(S) FOR REFERRAL

- | | |
|-------------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Medication non-compliance | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Non-adherence to treatment regimen | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Maternity | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Catastrophic illness/injury | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Multiple providers | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Multiple ER/Urgent Care Visits | <input type="checkbox"/> Other _____ |

 Signature of person completing form Fax # Date

YOUR PATIENT'S NURSE CARE MANAGER WILL BE _____
 Phone # _____

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This confidential information belongs to the sender, which is legally or medically privileged information. If you received this facsimile in error, please notify us at (417) 820-8880 or (800) 662-9962