Case Management Referral Form

BlueCross BlueShield of Kansas

Section 1 – Patient Information

CLEAR DATA

First Name _____ MI _____

(_____) _____-_____ Preferred Phone Number

(_____) _____-_____ Alternate Phone Number

Last Name _____

Preferred contact time: ☐ Morning ☐ Afternoon

BCBSKS ID Number _____

Date of Birth _____ / _____ / _____

Provider Name _____

Section 2 – Reason for Referral

Check all that apply:

- ☐ Complex wound management
- ☐ Head injury or stroke
- ☐ Multiple trauma
- ☐ Ventilator dependency
- ☐ High-risk pregnancy
- ☐ Multiple ED visits
- ☐ Identification of community resources
- ☐ Pain management
- ☐ Other _____
- ☐ Premature/high-risk infant
- ☐ Prescription drug assistance
- ☐ Progressive neuromuscular disease (MS, Parkinson's, ALS, etc.)
- ☐ Multiple readmissions
- ☐ End-of-life care
- ☐ Severe burns
- ☐ Transplants
- ☐ Spinal cord injury

Is patient also being referred to disease management? ☐ Yes ☐ No

List current medications:

_____

_____

_____

_____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

(attach separate sheet if more space is necessary)

_____ Form Completed By

_____ / _____ / _____ Date Completed

Send completed referral information to our case managers via:

Phone: 800-432-0216, ext. 6628 or 6611 (for FEP) **or** Fax: 785-291-0741