Case Management Referral Form

Provider, self or member, family, friend or other can send a referral to Case Management via phone, fax or email. Please use this form to provide pertinent information on who needs support, who is requesting services and the reason why case management or care coordination is needed. All referrals go directly to Case Management office.

Send referral to Comagine Health
Phone: 888-240-0437 | Fax: 877-265-9549 | Email: AKcasemanagementreferrals@comagine.org

If sending email, use *Attn: Case Management referral* in the subject line and include this form as an attachment.

A Comagine Health clinical case manager will contact the member or authorized representative by phone. Please allow two business days for a response.

Referral Source (Person Completing Form)

☐ **Provider** ☐ **Self or Member** ☐ **Family** ☐ **Friend** ☐ **Other:**

Name (First, MI, Last):	For Providers-NPI or PID Number:		
Phone Number:	Email Address:		
Address:	City:	State:	ZIP:

Member Information (Self)

Name (First, MI, Last):	Date of Birth:	Medicaid ID Number:	
Phone Number:	Email Address:		
Address:	City:	State:	ZIP:

Reason for Referral

Select option(s) that reflect what events, conditions or considerations the member is needing assistance or care coordination with:

☐ **Access to care barriers** (finding a provider, specialist, services, etc.)	☐ **Behavior or mental health issues**
☐ **Community services**	☐ **Frequent ER visits** (three or more in past 12 months)
☐ **Financial and/or social support**	☐ **Medication questions or concerns**
☐ **New diagnosis or injury**	☐ **New Medicaid enrollee**
☐ **Navigating benefits**	☐ **Understanding and support with medical condition**

☐ **Other** (Please provide details):

Any services or benefits already utilized this year?: