UniCare Health Plan of West Virginia, Inc.
Medicaid Managed Care

Case Management Referral Form

To be completed by person referring to Case Management or Continuity of Care.
When complete, please email to **wvcmreferrals@anthem.com**.

Member name: _____ Member date of birth: _____

Member phone number: _____ Member ID number: _____

Name of person submitting form: _____

Referrer phone number: _____ Date referred to Case Management: _____

Reason for Case Management referral

☐ **High-risk obstetrics**
- ☐ Hypertension — gestational or pre-existing
- ☐ Diabetes — gestational or pre-existing
- ☐ Current or previous preterm labor — labor occurring prior to 37 weeks gestational age
- ☐ History of preterm delivery — birth occurring prior to 37 weeks gestation
- ☐ Confirmed psychosocial issues (domestic abuse, depression) with plans to continue pregnancy
- ☐ Current substance abuse or treatment (including smoking) — type: _____
- ☐ Incompetent cervix ☐ Cerclage (date performed): _____
- ☐ Placenta previa/abruption
- ☐ Hyperemesis with weight loss of greater than 10 pounds from prepregnancy weight
- ☐ Other (specify high-risk medical condition): _____

☐ **Transplant**
- ☐ Type: _____ New referral (please check one): ☐ S ☐ P

☐ **Catastrophic conditions (adult and pediatric)**
- ☐ Catastrophic or complex diagnosis requiring coordination of care, connection to services and/or coordination of benefits
- ☐ Compounding psychosocial factors presenting actual or potential barriers to care
- ☐ Chronic conditions:
  - ☐ Requiring three or more hospitalizations within the past six months
  - ☐ Nonhealing wound requiring active treatment for a duration greater than three months
- ☐ Provider or member is requesting case management. Contact phone number: _____

☐ **HIV/AIDS**
- ☐ HIV
- ☐ AIDS

☐ **End-stage renal disease**
- ☐ Hemodialysis
- ☐ Peritoneal dialysis

Continuity of care services (services required due to physician contract terminations or member insurance changes)

Does the member have a need for continuation of services? _____

☐ Acute or chronic health care condition requiring completion of service to complete a course of treatment
☐ Pregnancy
☐ Terminal illness
☐ Surgery
☐ Newborn to 36 months
☐ Additional information or comments: _____

What do you think case management can impact with this referral? _____

Are medical records attached to this referral? ☐ Yes ☐ No

This section to be completed by the Case Management department.

Does the member have a need for continuation of services? _____

☐ Case management case opened. Assigned case manager: _____

☐ Case management case not opened — Check reason below:
- ☐ No active case management needed at this time.
- ☐ Member is not eligible for services.

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