



## Case Management Patient Referral Form

TriWest provides Case Management services for West Region TRICARE beneficiaries who: 1) Have a complex medical or behavioral health condition, 2) Have high risk psychosocial risk factors, 3) Receive medical care in the network, and 4) For whom CM services would likely reduce patient risk of adverse outcome.

To request Case Management services, please complete the information below and fax this form to the appropriate CM office (see next page for fax numbers and additional information.)

**Case Management Referral** \_\_\_\_\_

**Behavioral Health Case Management Referral** \_\_\_\_\_

**Extended Care Health Option (ECHO) Referral** \_\_\_\_\_

Patient Information:	Health Care Team Information:
Last Name _____	Referral Source _____
First Name _____	Phone No. ( ____ ) _____
Sponsor's SS No. _____	PCM _____
ID No. _____	Phone No. (s) ( ____ ) _____
Date of Birth _____	Fax No. (s) ( ____ ) _____
Home Address _____	Specialist(s) Involved in Care:
_____	Name(s) _____
Home Phone No. ( ____ ) _____	Phone No.(s) ( ____ ) _____
Cell/Other No. ( ____ ) _____	Fax No. (s) ( ____ ) _____
Primary Caregiver (If Applicable) _____	Is patient currently in Hospital, SNF or Rehab? If yes
Phone No(s) ( ____ ) _____	Name of Facility _____
Other Health Insurance: Medicare ____ Medicaid ____	Phone No.(s) ( ____ ) _____
VA ____ Other _____	Fax No. ( ____ ) _____

1. Diagnosis (s) \_\_\_\_\_

2. History of Present Illness / Condition / Recent Hospitalization(s) \_\_\_\_\_

3. Reason for Referral \_\_\_\_\_

\_\_\_\_\_

4. Has the beneficiary or primary caregiver been informed that a CM referral was being submitted? Yes \_\_\_\_ No \_\_\_\_

5. Does the patient need help in managing his/her treatment plan or coordinating services related to his/her health condition or diagnosis? Yes (please explain) \_\_\_\_\_ No \_\_\_\_

6. If Behavioral Health Referral, has the patient consented to Mental Health/Substance abuse services? Yes \_\_\_\_ No \_\_\_\_

7. Does the patient have help at home? Yes No If no, please explain \_\_\_\_\_

8. Is the patient currently receiving any of the following? None \_\_\_\_ HHC \_\_\_\_ Radiation Therapy \_\_\_\_  
Chemotherapy \_\_\_\_ SNF \_\_\_\_ Infusion \_\_\_\_ Inpatient Rehabilitation \_\_\_\_ OP Therapies \_\_\_\_  
Behavioral Health/Substance Treatment \_\_\_\_ Other (please explain) \_\_\_\_\_

9. Does the patient use any of the following equipment at home? Suction \_\_\_\_ Oxygen \_\_\_\_ CPAP/Bipap/apnea monitor \_\_\_\_ Wheelchair \_\_\_\_ Walker \_\_\_\_ Other Special Care Equipment \_\_\_\_\_

# Submitting a Case Management Referral to TriWest

Please fax this referral form, and any additional clinical information that may assist the Case Manager in providing services to your beneficiary, to the TriWest hub office responsible for the state in which the beneficiary resides.

**EXCEPTION:** All Transplant, hospice and cancer clinical trial programs are managed out of the Corporate Case Management Office.

<u>TriWest Case Management Hub Offices</u>	<u>Fax Number</u>
<b>Northwest Hub</b> – Washington, Oregon, Alaska, N. Idaho	1-866-269-5881
<b>Southwest Hub</b> – California, Nevada, Yuma Arizona	1-866-269-5828
<b>Mountain Hub</b> – Arizona, El Paso Texas, New Mexico, Utah, Montana, S. Idaho	1-866-269-5819
<b>Central Hub</b> – Colorado, Nebraska, Minnesota, Iowa, N Dakota, S Dakota, Wyoming, Missouri, Kansas	1-866-312-5840
<b>Hawaii Hub</b> – Hawaii	1-866-269-5814
<b>Corporate Office</b> – All Transplant, Hospice and Cancer Clinical Trial Referrals	1-866-269-5758

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## Case Management – General Information:

TriWest provides Case Management services for West Region TRICARE beneficiaries who:

- 1) have a complex medical or behavioral health condition,
- 2) have high risk psychosocial risk factors,
- 3) receive medical care in the network, and
- 4) for whom CM services would likely reduce patient risk of adverse outcome.

To request Case Management services, complete the requested information on page 1 and fax the form to the appropriate CM office – see above for fax numbers. Upon referral, a case manager will screen for the appropriateness of CM services and triage for urgency of initiating CM services. If the CM referral is not accepted, the referral source will be notified and provided with the reason for not accepting the referral. If the referral is accepted, a care plan will be completed and sent to the beneficiaries Primary Care Manager (PCM) or the behavioral health provider.

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## Examples of complex conditions with high risk clinical and psychosocial factors that should be considered for a CM Referral:

- Spinal Cord or Head traumatic injury with significant neurological deficits requiring assistance in coordinating rehab services
- Neonates – pre-maturity and/or congenital anomaly, requiring extensive post-hospital service coordination and family education to learn to manage independently
- Respiratory failure with new ventilator dependence post hospitalization
- Medically complex or fragile condition with co-morbidities requiring assistance with implementing treatment plan and breaking down access barriers
- Transplants – solid organ or stem cell
- Candidate for National Cancer Institute (NCI) Phase II or III Cancer Clinical Trial
- Child or Adolescent Residential Treatment Center admissions
- Pediatric Psych admission
- ECHO Registration
- Severely Injured Active Duty Service Member
- Life-Threatening Suicide Attempt

Privacy Act Statement - This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations of this may be punishable by fines, imprisonment, or both