Medical Management Services Referral Form

REFERRAL REQUESTOR INFORMATION		
Form Completed By:	**Your Phone:** **Your FAX:**	**Date:**
TPA/Insurance:		**Employer:**
PPO Network:	**Phone:**	**Group #:**

PATIENT INFORMATION			
Patient:	**ID#:**	**Date of Birth:**	**Gender:**
Insured:	**ID#:**	**Date of Birth:**	**Gender:**
Street Address: **City:**		**State:**	**ZIP:**
Phone*:		**Benefits Effective Date:**	
* **Important: If the phone number is not readily available at time of submission, please provide as soon as possible to assist us with a prompt outreach to the patient.**			

PROVIDER INFORMATION	
Provider of service: **Is facility in-network?** ☐ Yes ☐ No	**Physician:** **Is physician in-network?** ☐ Yes ☐ No
Address:	**Address:**
Phone:	**Phone:**
FAX:	**FAX:**
Contact:	**Contact:**

CLINICAL INFORMATION
Patient Diagnosis/Treatment Plan*: ***please include any pertinent clinical data with the fax.***

REASON FOR REFERRAL		
Case Management	**Maternity Management** (**not** High-risk Maternity CM)	**Disease Management**
☐ **Review for impact** ☐ **Stop Loss** ☐ **Open to CM** ☐ **Specialty Pharmacy Advocacy** ☐ **Refer for High-risk Maternity CM** ☐ **Refer for Medical Disclosure** ☐ **Refer to Bariatric CM** **Authorized signature to open CM:** _____	☐ **Refer for Maternity Management Program**	☐ **Refer for Disease Management Program**

COMMENTS

Please FAX completed form to 866-440-3487 or send via secure e-mail to CMCoordinators@ahhinc.com

Questions? Call 1-800-641-3224 for Case or Maternity Management or 1-800-451-6123 for Disease Management