**MSHO/MSC+ Medical Case Management/Behavioral Health Case Management Referral Form**

**\*\*For urgent medical or behavioral health symptoms (i.e. chest pain, shortness of breath, mental health crisis) please assist members in connecting with:**

* **24/7 Nurse Line 1-888-275-3974 (provides both medical and behavioral health crisis services)**
* **Primary Care Physician**

**AND**

* **Email this completed form to:** [**Medicaid.Clinical.Guide@bluecrossmn.com**](mailto:Medicaid.Clinical.Guide@bluecrossmn.com)

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| **REFERRAL TO CASE MANAGEMENT** |
| Date of Referral to Case Management: Click here to enter text.  Care Coordinator made a referral to:  Nurse Line  Primary Care Physician  Type of Referral  Medical CM  Behavioral Health CM |
| Reason for the Referral: Click here to enter text.  Has member been notified of the referral: Click here to enter text. |
| Member Name: Click here to enter text.  DOB: Click here to enter text.  Member ID: Click here to enter text.  Updated Contact Information (if applicable): Click here to enter text.  Care Coordinator Name: Click here to enter text.  Care Coordinator Phone Number: Click here to enter text.  Care Coordinator Email Address: Click here to enter text.  Interpreter Needed:  Yes  No  Language: Click here to enter text. |

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| **REQUESTING CASE CONSULTATION ONLY** |
| Date of Case Consult Request: Click here to enter text.  Type of Consultation**:**  Medical CM  Behavioral Health CM  Reason for consult: Click here to enter text. |
| Member Name: Click here to enter text.  DOB: Click here to enter text.  Member ID: Click here to enter text.  Care Coordinator Name: Click here to enter text.  Care Coordinator Phone Number: Click here to enter text.  Care Coordinator Email Address: Click here to enter text. |