**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, if applicable:

* For Medical Crisis: dial 911
* For Mental Health Crisis: dial 988 National Suicide Hotline
* 24/7 Nurse Line: 1-888-275-3974
* Primary Care Physician

**AND**

* Email this completed form to: Medicaid.Clinical.Guide@bluecrossmn.com

|  |
| --- |
| **REFERRAL TO CASE MANAGEMENT***Complete this section when requesting direct member contact from a Case Manager or Clinical Guide.* |
| Date of Referral to Case Management: Click here to enter text.**Care Coordinator made a referral to, if applicable:** [ ]  Nurse Line [ ]  911 [ ]  Primary Care Physician [ ]  National suicide hotline **Type of Referral**[ ]  Medical CM (short term goal-oriented chronic condition management) [ ]  Behavioral Health CM (short term goal-oriented behavioral Health condition management. Connecting members to mental health providers in their community) |
| **Detailed Reason for Referral** (What support needs does the member have? What specific resources is the member needing? What symptoms are they experiencing?): 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 [ ]  NoLanguage: Click here to enter text. If the referral includes speaking to spouse or advocate instead of the member, does the member have an [Authorization for disclosure of health information (ADHI)](https://www.bluecrossmn.com/member-resources/member-documents-forms) on file with Blue Plus. If not, please assist with completing this form. |

|  |
| --- |
| **REQUESTING CASE CONSULTATION ONLY***Complete this section when requesting Care Coordinator case consultation only with a Clinical Guide. The Clinical Guide can provide support to the Care Coordinator including discussion of complex cases, referral to resources, and how to proceed with supporting a member.*  |
| Date of Case Consult Request: Click here to enter text.**Type of Consultation:**[ ]  Medical CM[ ]  Behavioral Health CM Member Diagnoses: Click here to enter text.Detailed 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. |