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| <p>Contact Information</p> | <p>Case Management Program Care Coordination Department Fax: 850-523-7275</p> |
| <p>Purpose</p> | <p>The CHP Case Management Program coordinates services for members with multiple or complex conditions and helps them obtain access to appropriate care and resources beyond a single episode of care. This improves health care delivery and management while promoting quality cost-effective outcomes in the appropriate setting.</p> |
| <p>Which Members to Refer</p> | <p>Case Management is a benefit available to all members of Capital Health Plan who meet the initial screening criteria.</p> |
| <p>Referral Criteria</p> | <p>Criteria for initial screening for the Case Management Program include members with:</p> <ul style="list-style-type: none"> • Complex conditions needing short-term interventions • Multiple related hospital or ER admissions • Complex discharge planning or care management needs |
| <p>Examples</p> | <ul style="list-style-type: none"> • Complex conditions such as diagnoses with recurrent or ongoing problems or complications. • Catastrophic conditions such as: acute CVA with residual deficits or severe trauma. • Hospital admissions due to challenging outpatient management. • Hospital readmissions for the same or related diagnoses or non-compliance to treatment plan. • Hospital stays with extended length of stays for diagnosis or procedure. • Emergency room over-utilization for the same or related diagnoses. |

Case Management Program Referral Form

The CHP Case Management Program coordinates services for members with multiple or complex conditions and helps them obtain access to appropriate care and resources beyond a single episode of care. This improves health care delivery and management while promoting quality cost-effective outcomes in the appropriate setting.

Criteria for initial screening for the Case Management Program include members with :

- Complex conditions
- Multiple related hospital or ER admissions
- Complex discharge planning or Care Management needs

Please refer those members whom you feel would benefit from case management services. We will evaluate for inclusion into the program and will notify you of our decision within 5 working days.

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| Date: | CHP Identification #: |
| Member Name: | DOB: |
| PCP: | Member Contact Number: |
| Referral Source Name/Phone/Department: | |
| Member/Caregiver Self-Referral (circle one): | Yes No |
| Reason for Referral to the Case Management Program: | |

Please fax this request along with recent/pertinent medical records to the Case Management Program at (850) 523-7275.