Care Management Referral Form

Fax to: 1-866-287-3286

Please print or type requested information below.

Mail available medical records to:
Attn: Case and Disease Management
WellCare Health Plans, Inc.
P.O. Box 31401
Tampa, FL 33631-3401

Date: **Referral Date:**

CHECK ONE OF THE FOLLOWING:	
Case Management ☐	**Disease Management** ☐
PATIENT INFORMATION *Please verify with patients that all demographic information is correct for timely and effective processing.*	
County	**Member Phone #:**
Member Name (Last, First, MI):	**Member DOB:**
Member Address (Full Address):	
Subscriber ID #:	
PCP Name:	**PCP Phone Number:**
Hospital Name:	**Hospital Phone Number:**

REFERRAL INFORMATION	
Name of Referring PCP or Specialist (Full Name)**:**	
Phone Number: (Include Area Code)	**Fax Number:** (Include Area Code)
REASON FOR REFERRAL: (Include CLINICAL INFORMATION below)	

DIAGNOSIS: (Include CLINICAL INFORMATION below)

CASE MANAGEMENT USE ONLY	
CM STATUS ☐ Accepted ☐ Rejected	CM Screening Date:
Screened by:	Assigned to CM: Fill in if different from reviewer name
Reason for REJECTION:	

Form Revised by: TReese
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