DISEASE AND CASE MANAGEMENT REFERRAL

FAX Form to SECUR Health Plan: 833.852.3607

***** PLEASE DO NOT SEND REQUESTS FOR MULTIPLE MEMBERS TOGETHER IN ONE FAX – MUST SEND SEPARATELY*****

MEMBER INFOMATION	
Member Name	
Date of Birth	Member's Plan ID
Name of Nursing Facility	Referring Provider
Referring Provider	☐ Plan NP ☐ PCP ☐ Plan PA ☐ Other
Diagnoses (ICD-10 Codes)	

PROVIDER INFORMATION	
Provider Name	Provider Contact Number
Specialist Name	Fax

Please check the Disease and Case Management Program, you wish the member to be evaluated for participation:

☐ Alcohol and Drug Dependence ☐ Autoimmune Disorders Cancer ☐ Cardiovascular Disease
☐ Chronic Lung Disorder ☐ Diabetes ☐ End-stage Liver Disease ☐ End-stage Renal Disease
☐ Mental Health Disorder ☐ Neurologic Disorder ☐ Severe Hematologic Disorder ☐ Stroke

Please provide pertinent medical information and any details about current status of member.

FOR DISEASE AND CASE MANAGEMENT USE ONLY	
Date Received	Date Evaluated
Disease Management Determination ☐ Approved ☐ Not Approved	
Comments	
Name of Case Manager	Date