Molina Healthcare Care Management Program Referral Form and Instructions

Information about our care management programs

Molina Healthcare offers care management services to members with chronic and complex medical and/or behavioral health conditions and identified socioeconomic barriers. These care management programs assist members and their providers in managing their condition(s) as well as following the prescribed treatment plan. We also offer integrated care management to members with a dual diagnosis.

To better support our providers and members, we created a care management referral form that providers can complete and fax directly to us when providers identify a member who may benefit from the care management services we offer.

Our care management services

Population management is an intermediate level care management program that focuses on helping members develop self-management skills, arranging services and providing health education for members with specific medical, behavioral and social needs.

Additionally, population management interventions may include smoking cessation, diet and nutritional counseling, wellness and prevention and other for the following targeted medical populations:

- Diabetes
- Heart failure
- Hypertension
- Pregnancy and high-risk pregnancy
- Asthma
- Coronary heart disease
- Chronic obstructive pulmonary disease

Complex care management targets the most complex, highest risk members, including those with special health care needs for which a multidisciplinary approach is utilized, focusing on helping members develop self-management skills, arranging needed services and providing education to meet the various health needs of this population.

Medical conditions that may be appropriate for a care management referral include, but are not limited to:

- Cancer
- HIV
- CVA or other degenerative neurological or neuromuscular disorders
- Spinal cord injury, traumatic brain injury or anoxic brain injury
- Complex newborn/NICU stay
- Neonatal abstinence syndrome or shaken baby syndrome

Indications that a patient may benefit from a referral for complex care management for any medical condition include but are not limited to:

- An illness or event that has caused a change or decline in the ability to self-manage
- Five or more chronic condition medications
- Five or more different specialists
- An acute inpatient hospital visit with a length of stay greater than seven days
- Multiple admissions and/or readmissions
- Multiple or repeated emergency department usage
- Homelessness or poor or inadequate living environment

How to complete the care management referral form

1. Complete the member information section. Please include the member's most current demographic information.

2. Complete the referring provider information section.
   a. Include the referring provider's most current demographic information and NPI number.
   b. Include any agency-related information, if applicable.

3. Include pertinent member clinical information.
   a. Include the member's diagnosis.
   b. Include any relevant clinical information.
   c. Indicate the reason for the referral to a care management program.

Molina Healthcare Care Management Program Referral Form

Please fax this to (888) 656-7503. If you have questions, please contact Molina at (800) 424-5891.

Member Information		
Member Name	Molina ID Number	
Member DOB	Gender	
Member Guardian		
Home Phone Number	Mobile Phone Number	
Member Address		
City	State	ZIP Code
Referring Provider Information		
Provider Name	NPI Number	
PCP or Specialist	Referring Provider/Group Name	
Referring Provider/Group Name NPI Number		
Individual's name and group name if affiliated with multiple groups (N/A if not applicable)		
Referring Provider's Phone Number	Referring Provider's Fax Number	
If applicable, please describe any agency involvement		
Member Diagnosis		
Please select the care management program you are requesting for this member ☐ Population Health ☐ Complex Care		
Pertinent Clinical Information		
Reason for referral to care management		