Molina of Washington Care Management Referral Form

Fax: (800) 767-7188
Phone: (800) 869-7165

Date: _____

Referral Source Information

Person Making Referral: _____ Office Name: _____

Phone Number: _____

Referring Provider: _____ Specialty: _____

Telephone Number: _____ Diagnoses: _____

Patient Information

Name: _____ DOB: _____

Address: _____

Telephone Number: _____

Patient's Current Location If Other Than Residence: _____

Molina Member ID #: _____ OR Provider One ID #: _____

Reason for Referral

Member needs support with the following areas (check all that apply):
***Please attach clinical notes if available.**

- ☐ Catastrophic- medical or trauma related
- ☐ Chronic condition or recurring medical problems
- ☐ Functional or emotional impairment
- ☐ Pediatric/Neonatal
- ☐ Mentally, physically handicapped or developmentally disabled
- ☐ Multiple Hospitalizations/ER visits/Multiple Surgeries
- ☐ OB-GYN (high risk)
- ☐ Organ Transplant/Single/Multiple Organ Failure
- ☐ Behavioral Health/Chemical Dependency

- ☐ Housing Assistance
- ☐ Assistance with obtaining food
- ☐ PCP/Specialist Appointment Set up
- ☐ Transportation
- ☐ Community Resources
- ☐ Understanding health care benefits

Member needs assistance managing one or more of the following chronic conditions:

- ☐ Asthma
- ☐ CHF
- ☐ COPD
- ☐ CVD
- ☐ Diabetes
- ☐ Depression
- ☐ Obesity
- ☐ Prediabetes
- ☐ Other

☐ Other (please specify): _____