DENVER HEALTH MEDICAL PLAN INC.

MEDICAL MANAGEMENT REFERRAL FORM

Have you spoken to your patient about this referral? (check one): ☐ Yes ☐ No

Full Name (Last, First, Middle Initial) _____

Date of Referral _____

Medical Record # (MRN) _____

Member ID # _____

Date of Birth (DOB) _____

Member Telephone # _____

Clinic Name _____

Primary Care Provider (PCP) _____

Referred By _____

Parent/Guardian Name _____

Preferred Language (check one): ◯ English ◯ Spanish ◯ Russian ◯ Other _____

Insurance (check one):

◯ Denver Health Medicaid Choice (DHMC)
◯ Child Health Plan Plus (CHP+)
◯ Denver Health Medicare Choice HMO SNP and Select HMO
◯ Elevate Health Plans
◯ DHMP Employer Group Plans (DHHA, City & County of Denver, DERP, Denver Police)

Brief history and reason for referral: _____

MEDICAL MANAGEMENT SERVICES

Health Mangement:
- » Health behavior change
- » Self-management of chronic conditions
- » Disease management
- » Emotional well-being
- » Complex case management
- » Regular/ongoing care coordination
- » Regular/ongoing resource referrals
- » Disease process education
- » High utilization of services

Pharmacy Services:
- » Medication education
- » Pain management
- » Medication review
- » Medication management

Member Services:
- » Eligibility
- » Benefit information
- » Appointment assistance
- » Grievance and appeals

Medicare/Medicaid plans:
- » Transportation assistance

Please complete this form and email to: DHMPCC@dhha.org
Questions? Call 303-602-2184

Thank you for your referral to Medical Management. Our staff will review your request, contact the member and determine need. A referral to the appropriate program will occur. We will notify you with receipt of your referral.