

Is this a self-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)

 Denver Health Medicare Choice HMO SNP and Select HMO

 DHMP Employer Group Plans (DHHA, City & County of Denver/DERP, Denver Police)

 Child Health Plan Plus (CHP+)

 Elevate Health Plans

Brief history and reason for referral: _____

MEDICAL MANAGEMENT SERVICES
Health Management:

- » Self-management of chronic conditions
- » Disease management
- » Emotional well-being

Care Management Services:

- » Complex case management
- » Transitions of care coordination
- » 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 / Fax 303-602-2146

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