DENVER HEALTH MEDICAL PLAN INC.™

CARE MANAGEMENT REFERRAL FORM

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):
Medicaid Choice Child Health Plan *Plus* (CHP+)
Medicare Advantage Exchange/CO Option DHHA

Brief history and reason for referral: _____

MEDICAL MANAGEMENT SERVICES

Health Mangement:
- » Self-management of chronic conditions
- » Disease management
- » Emotional well-being

Care Mangement 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

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