



# Case Management Patient Referral Form

TriWest provides Case Management (CM) services for West Region TRICARE beneficiaries who:

- Have a complex medical, surgical or behavioral health condition
- Have high-risk psychosocial risk factors
- Receive medical care in the TRICARE civilian network.

To request Case Management services, please fax this completed form to the TriWest hub office responsible for the state in which the beneficiary resides. Please include any additional information that may assist the Case Manager in providing services to your beneficiary.

Hub	States Included	Fax Number
<b>Northwest</b>	Alaska; Northern Idaho; Oregon; Washington	1-866-269-5881
<b>Southwest</b>	Yuma, Arizona; California; Nevada	1-866-269-5828
<b>Mountain</b>	Arizona; Southern Idaho; Montana; New Mexico; El Paso, Texas; Utah	1-866-269-5819
<b>Central</b>	Colorado; Iowa; Kansas; Minnesota; Missouri; Nebraska; North Dakota; South Dakota; Wyoming;	1-866-312-5840
<b>Hawaii</b>	Hawaii	1-866-269-5814
<b>Corporate</b>	Transplant Referrals (region-wide)	1-866-269-5758

Please check **one** box below – the type of referral being made:

- Medical/Surgical**    
 **Behavioral Health**    
 **Transplant**

### Patient Information (please print)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Sponsor's Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone Number: (\_\_\_\_) \_\_\_\_\_ Cell/Other Number: (\_\_\_\_) \_\_\_\_\_

### Referral Source Information (please print)

Name of Person Completing Form: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Patient's Primary Physician: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Specialist(s) Involved in Care:

Name(s): \_\_\_\_\_

Phone Number(s): (\_\_\_\_) \_\_\_\_\_ Fax Number(s): (\_\_\_\_) \_\_\_\_\_

- Reason for Referral \_\_\_\_\_
- Is the patient currently receiving any of the following?
  - None
  - Inpatient Acute Care
  - Home Health Care
  - Chemotherapy
  - Infusion
  - Inpatient Rehabilitation
  - Outpatient Therapies
  - Radiation Therapy
  - SNF
  - Behavioral Health/Substance Treatment
  - Other (please explain) \_\_\_\_\_
- Has the beneficiary or primary caregiver been informed that a CM referral was being submitted? Yes \_\_\_\_ No \_\_\_\_
- If Behavioral Health Referral, has the patient consented to Mental Health/Substance abuse services? Yes \_\_\_\_ No \_\_\_\_