Case and Disease Management Referral Form

ULTIMATE HEALTH PLANS
Good health is where you live.

Please submit this completed form to UHP Case Management Department via fax: 352-277-5309

Referral Source Information

Name of Referring Physician/Source:	Date:
Please check if: ❑PCP ❑Specialist ❑Other:	

Member Information

UHP ID#:	Member Name:			DOB:
Member Address:				Phone:
Apt. #:	City:	State:	Zip:	County:

Case Management Referral (please check Case Management services needed)

❑Coordinate Benefits/Care ❑Assessment ❑Discharge Planning ❑Onsite Visit

❑Care Plan Development ❑Vendor Communication ❑Other:

Comments:

Disease Management Referral (please check Disease Management services needed)

❑CVD ❑CHF ❑COPD ❑Diabetes ❑Asthma ❑Other:

Comments:

Social Services Referral (please check Social Services needed)

❑Community Resources ❑Contact Family ❑Onsite Visit ❑Other:

Comments:

Additional Information (optional)

PCP Appt. Date:	Spec. Appt. Date:	HHC:	DME:
Member Notified of Referral? ❑Yes ❑No	New Prescriptions:	Comments:	

For UHP USE Only – Case Management Recommendations

Program(s): ❑CM ❑DM ❑SS CM Screening Date: _____ Accepted? ❑Y ❑N Participating? ❑Y ❑N

Referral Source Notify Date:_____Comments: