

## PROVIDER REFERRAL FORM FOR CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAMS

Contact Name:  Referral Date:  Phone:  Fax:  Email:  Member Information:  Name: Date of Birth:  Medicaid ID #:  Street Address: City, State, Zip: Phone:  PROVIDER: Please place check by all applicable diagnoses for this member:  Congestive Heart Failure  Congestive Heart Failure  Congestive Heart Failure  Copp  Cystic Fibrosis  Diabetes  Prematurity & Developmental Delays  Cystic Fibrosis  Diabetes  Hemophilia  HIV/AIDS  Pregnancy; must submit Notification of Pregnancy (NOP) form  Hypertension  Other (please list in space below):  PROVIDER: Please provide responses, as applicable, for this member:  Number of Emergency Room visits during previous 6 months  Number of inpatient hospital admissions during previous 12 months  PROVIDER: Once form is completed, please mail or fax to:  Mail:  Magnolia Health Plan, Inc. Attn: Medical Management 111 East Capitol Street, Suite 500 Jackson, MS 39201  Fax:  866-901-5813  Phone:  To speak to a care manager regarding your request call 1-866-912-6285 (Relay 711).	Provider Information:				
Phone: Fax: Email:    Email:	Contact Name:				
Fax: Email:    Member Information:	Referral Date:				
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