



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

<b>Provider Information:</b>	
Contact Name:	
Referral Date:	
Phone:	
Fax:	
Email:	

<b>Member Information:</b>	
Name:	
Date of Birth:	
Medicaid ID #:	
Street Address:	
City, State, Zip:	
Phone:	

<b>PROVIDER: Please place check by all applicable diagnoses for this member:</b>			
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Coronary Heart Disease	<input type="checkbox"/>	Prematurity & Developmental Delays
<input type="checkbox"/>	COPD	<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Smoking Cessation
<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Pregnancy ; must submit <i>Notification of Pregnancy (NOP)</i> form
<input type="checkbox"/>	HIV/AIDS		
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Other (please list in space below):

<b>PROVIDER: Please provide responses, as applicable, for this member:</b>	
<input type="checkbox"/>	Number of Emergency Room visits during previous 6 months
<input type="checkbox"/>	Number of inpatient hospital admissions during previous 12 months

<b>PROVIDER: Once form is completed, please mail or fax to:</b>	
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).