PROVIDER REFERRAL FORM FOR
CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAMS

Provider Information:	
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:			
	Asthma		Kidney Disease
	Congestive Heart Failure		Obesity
	Coronary Heart Disease		Prematurity & Developmental Delays
	COPD		Sickle Cell Disease
	Cystic Fibrosis		Depression
	Diabetes		Smoking Cessation
	Hemophilia		Pregnancy ; must submit *Notification of Pregnancy* (NOP) form
	HIV/AIDS		
	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.