BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER MANAGEMENT REFERRAL FORM

Please fax completed form to the appropriate area below
The numbers below are for CM referrals only. No precert referrals should be faxed to these numbers.

Behavioral Health 1-816-237-2397
General Medical 205-220-0130
Neonatal 205-402-5846
Obstetrical 205-733-6460
Oncology 205-733-7304
Transplant 205-402-9294

Please check (✓) the appropriate box.

Case Management Referral: ☐

Transitions of Care Referral: ☐ Post-hospitalization for Congestive Heart Failure ☐ Coronary Arterial Bypass Graft (CABG)

Disease Management Referral: ☐ Asthma ☐ Coronary Artery Disease (CAD) ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Diabetes ☐ Heart Failure

Urgent Referral *(Please contact me.)* ☐

Informational Referral Only *(Do not contact me.)* ☐

Referral Date

Patient Information

Patient Full Name:

Date of Birth

Address *(if discharge address is not same as home)*

City

State

Zip

Current Home Telephone Number or Cell Phone Number *(+ Area Code)*

Insurance Contract Number *(include prefix)*

Patient Clinical Information

Brief Clinical History:

Medications:

Discharge Plan:

Reason for Referral:

Follow-up Appointment Information

Provider Name and Title:

Phone Number *(+ Area Code)*

Appointment Date:

Hospital Information

Hospital:

Attending Physician Name:

UM/CM Contact Name:

UM/CM Phone Number: *(+ Area Code)*

Date Completed: