



# CARE COORDINATION REFERRAL FORM

PHONE 877-252-6002 | FAX 405-213-1145

Referral by: \_\_\_\_\_ Phone: \_\_\_\_\_ Referral date: \_\_\_\_\_

### REFERRAL SOURCE

- Primary Care Provider
- Emergency Department
- Community Agency
- Other
- Specialty Provider
- Caseworker/DC planner
- Transition Coordinator

### MEMBER INFORMATION

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Member DOB: \_\_\_\_\_ Member Phone: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Relationship to Member:  Self  Family  Other (specify): \_\_\_\_\_

### REASON FOR REFERRAL

- Member has chronic health issues such as diabetes, high blood pressure, heart disease, arthritis, or sickle cell disease
- Member is pregnant, experiencing at-risk or high-risk pregnancy
- Request for out-of-state services, meals and/or lodging assistance for in/out-of-state care, or non-SoonerRide transportation needs
- Community resources needed
- High emergency department utilization
- At risk newborn or child with special needs
- Other (please specify) \_\_\_\_\_
- Medication review needed (e.g., adult members with 4+ chronic meds OR 1 hospitalization in the past year)

**PLEASE DESCRIBE CONCERNS, REASONS FOR REFERRAL, AND ATTACH RELEVANT MEDICAL RECORDS. ATTACHING RELEVANT MEDICAL RECORDS WILL EXPEDITE CARE COORDINATION PROCESS.**

**INCOMPLETE FORMS WILL BE RETURNED**

HCA-24 Care Coordination Referral



#### ADDRESS

4345 N. Lincoln Blvd.  
Oklahoma City, OK 73105



#### WEBSITES

oklahoma.gov/ohca  
mysoonerCare.org



#### PHONE

Admin: 405-522-7300  
Helpline: 800-987-7767