INTERNAL REFERRAL FORM: CHRONIC CONDITION MANAGEMENT

Member Information:

Name: _____ Empower ID: _____ DOB: _____ Tier: _____

Physical Address: _____

Member telephone #: _____

GN Name: _____ GN Telephone: _____

Additional support person that may be contacted? _____

Telephone: _____

Population Category: (check all that apply) BH: _____ DD: _____ IDD: _____

Please provide a brief description as to why this member needs to be in CCM program:

_____

_____

Is member open to education related to a chronic condition?

_____

Does member have PCP? Yes____ No___

PCP Name/Telephone Number: _____

Does member have BH provider: Inpatient____ Outpatient_____

BH Provider Name: _____

BH Provider Contact Person: _____

BH Provider Telephone Number: _____

Eligible for CCM program: Yes____ No: _____

Referral Date: _____

Care Coordinator Name: _____

Telephone/Email: _____

Care Coordinator Supervisor: _____

Please send completed form to chronic.conditions@empowerarkansas.com