

Health Choice Arizona Pediatric / NICU Case Management Referral Form

*****Please send to*****

Pediatric / NICU Case Management
peditricscmhch@healthchoiceaz.com
Enter priority on subject line (Routine or Urgent)
Fax (480) 317-3358

Referral Priority:

Urgent (0 - 2 days) Routine (1-5 days)

Member Name: _____ Date of Birth: _____
ID Number: _____ Phone: _____
Address: _____ City: _____ Zip: _____
PCP: _____ PCP Phone: _____
PCP Address: _____ City: _____ Zip: _____

Case Management's goal is improvement in patient outcomes and satisfaction, high quality care and cost effectiveness of outpatient care, and appropriate utilization of inpatient stays.

Please check any of the following criteria:

ER visits or admits (2+ a month)
Chronic diagnosis or
Behavioral / mental health
Non-compliance with treatment / medications
ADL / financial or social problems
Education need

NICU - In-patient

Cardiac Defects Apnea
RDS Congenital defects
Failure to thrive Other:
< 34 Weeks

NICU - Graduate

Cardiac Defects Apnea
RDS Congenital defects
Failure to thrive Other:
< 34 Weeks

Why is member being referred to Case Management?

Diagnosis:

(HC) Person Referring: _____ Phone: _____ Date: _____
Who called HC about this referral? _____ Phone: _____

Case Management findings and follow-up notes: