Referral to Medicaid Care Management

Patient name: _____

Patient address: _____

Humana ID: _____ Pharmacy: _____

DOB: _____ Plan: _____

Effective date: _____ Type of referral: ☐ Routine ☐ Urgent

POA: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Family member name(s): _____

Relationship: _____

Home phone: _____ Cell phone: _____

Person making the referral: _____ Phone: _____

Patient's PCP: _____

PCP address/office phone/fax: _____

PCP email: _____

Referring patient to: ☐ Case management ☐ Disease management ☐ HumanaBeginnings™

Demographics (include level of function, living arrangements, transportation, challenges for patient, etc.):

_____

Problem list: _____

Hospitalizations (include date and name of hospital):

_____

Procedures/surgeries: _____

HEDIS® measures: _____

Other: _____

Please fax completed form to **833-939-1312** or send via email to:
KYMCDCaseManagement@humana.com

Toll-free case and disease management telephone: **888-285-1121**.

Humana Healthy Horizons® in Kentucky

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