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Case Management Fax Form

To:	Case Management Department
From:	
Phone:	
Date:	

Member Name:	
DOB:	
Medicaid #	
Member Address:	
Phone:	

PLEASE CHECK THE AREA OF CASE MANAGEMENT NEEDED FOR THIS MEMBER.

<input type="checkbox"/>	HROB/Pregnancy	<input type="checkbox"/>	Sickle Cell
<input type="checkbox"/>	NICU	<input type="checkbox"/>	Catastrophic
<input type="checkbox"/>	Chronic Condition: Diabetes, Kidney, Heart Failure, COPD, Hypertension, Etc.	<input type="checkbox"/>	Special Needs
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Lead
<input type="checkbox"/>	Infectious Disease	<input type="checkbox"/>	Pain Management
<input type="checkbox"/>	Non-Compliance or Potential Non-Compliance	<input type="checkbox"/>	Behavioral Health
<input type="checkbox"/>	Other:		

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The medical information that may be contained in this FAX
transmission is **CONFIDENTIAL AND PRIVILEGED**

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