peach state health plan™
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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.

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