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Atlanta, GA 30339
Phone: 1-800-504-8573
Fax: 1-866-532-8835

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

	OB Department/NICU		**Sickle Cell**
	Chronic Kidney		**Catastrophic**
	Diabetes		**Special Needs**
	Asthma		**Lead**
	Infectious Disease		**Pain Management**
	Non-Compliance or Potential Non-Compliance		**OTHER:**

Comments:

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WARNING: THIS FAX TRANSMISSION MAY CONTAIN
CONFIDENTIAL MEDICAL INFORMATION
The medical information that may be contained in this FAX transmission is CONFIDENTIAL AND PRIVILEGED

It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended recipient or the intended recipient's agent, you are hereby notified that you have received this transmission in error; please notify us immediately at the telephone number listed above. It is also requested that you immediately transmit the information received in error to our office at the above address by mail. Peach State Health Plan will reimburse you for this expense. Thank You. Authorized Signature: