BCBSAZ INTEGRATED CARE MANAGEMENT
REFERRAL FORM

FOR PROVIDER USE ONLY

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

To refer a BCBSAZ member to the BCBSAZ Integrated Care Management program, please complete this form and send in a SECURE email format to the Care Management team at **CM@azblue.com.**
For urgent/high priority requests: Email this form *and* call the Care Management team at **602-544-8982.**

DATE OF REFERRAL (MM/DD/YYYY) / /
Is this request urgent (requiring immediate response)? ☐ Yes ☐ No

REFERRING PROVIDER INFORMATION	
PERSON SUBMITTING REFERRAL	BEST CONTACT PHONE NUMBER
ORGANIZATION	MEMBER'S PRIMARY CARE PROVIDER if different from person submitting referral

MEMBER INFORMATION			
NAME (First)	(Middle)	(Last)	
ADDRESS	MEMBER ID NUMBER (include all numbers and letters)	DATE OF BIRTH (MM/DD/YYYY)	
CITY	STATE	ZIP CODE	
PHONE	ALTERNATE PHONE	BEST TIME OF DAY TO REACH MEMBER	
ALTERNATIVE CONTACT NAME	RELATIONSHIP TO MEMBER	ALTERNATE CONTACT PHONE	
Is the member aware that a referral is being made? ☐ Yes ☐ No	Is the member currently outpatient or inpatient? ☐ Outpatient ☐ Inpatient	If inpatient, which facility?	

This member currently has the following services:

☐ Home Care ☐ Clinical Trial ☐ Palliative Care ☐ Hospice ☐ Enrolled in another Care Management program

☐ Other (brief explanation):

1308067-23

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Use the checkboxes to indicate the member's situation and types of care that may be needed. For each box checked, include a brief explanation in the comment box below. For high-risk pregnancy, also complete Section 5.

1. HIGH-RISK CARE MANAGEMENT

- ☐ Uncontrolled complex conditions (including medical, mental health, and substance use disorders) impacting multiple systems
- ☐ Complex discharge needs or post-discharge assistance
- ☐ Recent neurological injury or traumatic event/injury
- ☐ High-risk pregnancy (e.g., gestational diabetes, twins, behavioral health conditions, etc.) - Please complete Section 5 for specific clinical information.
- ☐ High-risk newborn
- ☐ Member being evaluated or waiting for transplant or bariatric surgery
- ☐ Adherence to treatment/care plan; barriers to achieving goals
- ☐ Assistance with medications (education and compliance)
- ☐ Other

2. MEMBER EDUCATION/COACHING/PREVENTION

- ☐ Coaching for self-management, self-care, or adherence with care-gap closure actions
- ☐ Chronic condition/disease education and support
- ☐ Newly diagnosed condition(s)
- ☐ Other

3. PSYCHO-SOCIAL/LONG-TERM CARE PLANNING

- ☐ Crisis management
- ☐ Behavioral health conditions and substance use disorders
- ☐ Alzheimer's disease or other brain disorder
- ☐ Home safety concerns (e.g., fall risk, violence, neglect, etc.)
- ☐ Advance directives/end-of-life planning
- ☐ Caregiver distress/family support resources
- ☐ Community resources (e.g., financial needs, housing, transportation, support groups , etc.)
- ☐ Other

4. OTHER

For all boxes checked above, explain the member's specific situation and care needs. For high-risk pregnancy, complete Section 5.

Note: Document contains PHI - send in SECURE format

SAVE form and send in SECURE email format to CM@azblue.com

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5. HIGH-RISK PREGNANCY

CLINICAL INFORMATION

LMP _____/____/_____ (☐ Not known) EDD _____/____/_____ (From ☐ LMP ☐ U/S)

Date of entry into prenatal care _____/____/_____ Date of first visit in provider's office _____/____/_____

Pre-Pregnancy Weight _____ (☐ Not known) Current Weight _____ Height _____

History

Total number of pregnancies _____

Number of deliveries after 37 0/7 weeks _____

Number of deliveries 32 0/7 –36 6/7 weeks _____

Number of deliveries before 32 weeks _____

History

Number of living children _____

Number of miscarriages/terminations _____

Number of cesarean deliveries _____

Number of VBAC deliveries _____

Condition (Check all that apply)	Current	Prior
TWINS	☐	☐
OTHER MULTIPLE_____	☐	☐
GESTATIONAL DIABETES	☐	☐
TYPE 1 or 2 DIABETES	☐	☐
PIH / PRE-ECLAMPSIA	☐	☐
ECLAMPSIA	☐	☐
CHRONIC HYPERTENSION	☐	☐
FETAL ANOMALIES	☐	☐
GENETIC DISORDER	☐	☐
BEHAVIORAL HEALTH	☐	☐
DOMESTIC VIOLENCE	☐	☐
OTHER OBSTETRICAL COND	☐	☐
OTHER MEDICAL CONDITIONS	☐	☐

Condition (Check all that apply)	Current	Prior
PRETERM BIRTH	☐	☐
INCOMPETENT CERVIX	☐	☐
PLACENTA PREVIA	☐	☐
PLACENTAL ABRUPTION	☐	☐
POST PARTUM HEMORRHAGE	☐	☐
SEIZURE DISORDER	☐	☐
HEART DISEASE	☐	☐
RENAL DISEASE	☐	☐
HEPATIC DISEASE	☐	☐
INFECTIOUS DISEASE	☐	☐
SUBSTANCE ABUSE	☐	☐
TOBACCO USE	☐	☐
HIV	☐	☐

For all boxes checked above, explain the member's specific situation and care needs.

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