

# Magellan Behavioral Health Case Management Referral Form

Email to:  
[medicalicmreferrals@magellanhealth.com](mailto:medicalicmreferrals@magellanhealth.com)  
 ICM contacts:  
 Pam Glover 678 319 3730  
 Roger Matthews 678 319 3782  
 Richard Griffin, LCSW 678 319 3761 ICM TEAM LEAD  
 Eileen O'Regan-O'Toole LCSW 678-319-3766 ICM /Co Located Supervisor

<b>DATE OF INITIAL CONTACT:</b>
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## MEMBER DEMOGRAPHICS

<b>LAST NAME:</b>		<b>FIRST NAME:</b>	
<b>DATE OF BIRTH:</b>		<b>AGE:</b>	
<b>MEMBER ID#:</b>			
<b>VERIFIED PHONE NUMBER:</b>			
<b>NAME of PARENT/GUARDIAN:</b>			

## REFERRAL INFORMATION

<b>REFERRED BY:</b>			
<b>PHONE NUMBER/Ext:</b>		<b>EMAIL:</b>	
<b>WAS CONSENT GIVEN?</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>MEDICAL DIAGNOSIS:</b>			<b>BH DIAGNOSIS:</b>
<b>MEDICAL AND/OR BH MEDICATIONS:</b>			
<b>REFERRAL IS FOR:</b>	<input type="checkbox"/> Intensive Case Management <i>(BH management only)</i> <input type="checkbox"/> Medical-Behavioral Case Management <i>(Medical and BH management)</i>		
<b>REASON FOR REFERRAL:</b>	<input type="checkbox"/> Readmit to inpatient or residential treatment facility in 60 days <input type="checkbox"/> Member has eating disorder diagnosis with an inpatient admit <input type="checkbox"/> Member < 12 years with inpatient or residential admit <input type="checkbox"/> Member has a significant BH condition which is untreated, undiagnosed, or not being managed by a provider <input type="checkbox"/> Extensive BH treatment history and issues related to BH non-compliance and/or limited support <input type="checkbox"/> Member's BH or SA condition appears to exacerbate his/her medical condition, increasing the likelihood of admission or readmission		
<b>PRESENTING PROBLEMS/ SYMPTOMS/CLINICAL STATUS:</b>	*Please include any screening scores ** If substance use/abuse, please list substance, amount and frequency of use		
<b>AVAILABLE SUPPORTS/ LIVING SITUATION:</b>			
<b>MEMBER CURRENTLY IN TREATMENT:</b>	<input type="checkbox"/> PCP Name _____ Phone _____ <input type="checkbox"/> Medical SCP Name _____ Type _____ Phone _____ <input type="checkbox"/> Psychiatrist Name _____ Phone _____		

<b>DATE TO MAGELLAN:</b>		<b>DATE RECEIVED BY MAGELLAN:</b>
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# Magellan Behavioral Health Case Management Referral Form

Magellan Response: [WELLCARE MED PSYCH REFERRAL INTAKE FORM](#)

REFERRING MCM: (name and contact #)

MEMBER:

PRESENTING CLINICAL:

SUICIDAL/HOMICIDAL RISK

LIVING SITUATION/SUPPORT SYSTEM:

POTENTIAL TX BARRIERS:

SUBSTANCE USE/ABUSE

MEDICAL CONCERNS:

MEDICATIONS:

ICM CRITERIA MET:

REVIEWER ACTION:

**Magellan Staff Name & Contact #:**