carelon

Behavioral Health Case Management Referral Form

Return via secure email to: beacontexas.icm@carelon.com Or
Fax to 1-855-371-9227

Referral Information					
Referral Source:		Referral Phone:		Date:	
Referral Email:		Member in Medical Case Mgmt: ☐Yes ☐No			
Medical Case Mgr *Name/Email*:					

Member Information					
Member Name:		DOB:		Member ID:	
Address:		Gender:	☐M ☐F		
Responsible Party (legal guardian name):		Member Phone:			
Language spoken at home/cultural issues:		Legal Status/Issues:			
Health Plan:		Type of Coverage: ☐Medicaid ☐ CHIP ☐HIM/Commercial			

Time Frame re: Follow-Up: ☐Routine (within 7 days) ☐Urgent (24-48 hours)
Was the member informed they would be referred and contacted by Beacon Case Management Staff? ☐ Yes ☐No If No, list reason:
Detailed Reason for Referral (note any special needs, including any dual diagnosis issues and/or urgency details):

Indicate Agency or Facility Contacts:		
Facility/Agency Name	**Contact Person**	**Phone#**

Behavioral Health Diagnosis (Refer to DSM V):	
DSM – 5	**ICD – 10**
Primary Diagnosis:	
Additional BH/SA Diagnoses:	

Medical Diagnosis (Refer to ICD-10)	
	ICD – 10
Primary Diagnosis:	
Additional Diagnosis:	