

## Care/Case Management Referral Form

MEMBER INFORMATION:	
Date of Request:	
Member Full Name:	
Member Date of Birth:	
Parent/Guardian (If Minor):	
Member Phone:	
Member ID:	
Member Plan Email*:	<ul> <li>Horizon Medicare Blue Advantage (HMO): MedicareAdvantageHMOBLUE_Referrals@HorizonBlue.com</li> <li>Horizon NJ Direct Medicare Advantage PPO: MedicareAdvantage_Referrals@HorizonBlue.com</li> <li>Horizon NJ Health: Medicaid_Referrals@HorizonBlue.com</li> <li>Horizon NJ TotalCare (HMO D-SNP): DSNP_Referrals@HorizonBlue.com</li> <li>Managed Long-Term Services &amp; Supports (MLTSS): MLTSS_Referrals@HorizonBlue.com</li> </ul>

REFERRAL INFORMATION:		
Referring Facility:		
Referral Source:		

## REFERRAL REASON (Please check all that apply):

Change in condition		
D Wound care		
Dest-Acute Transitional (PAT) Care required		
Enrolled in Horizon NJ Total Care (HMO D-SNP)		
Psychosocial (impact ability to stay at home)		
Maternity		
Social determination (Homeless, Placement post-acute discharge)		

Comments: \_\_\_\_\_

\*Please ensure that all forms are complete and sent to the correct email address, according to the member's plan.

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