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*:	❑ Horizon Medicare Blue Advantage (HMO): **MedicareAdvantageHMOBLUE_Referrals@HorizonBlue.com** ❑ Horizon NJ Direct Medicare Advantage PPO: **MedicareAdvantage_Referrals@HorizonBlue.com** ❑ Horizon NJ Health: **Medicaid_Referrals@HorizonBlue.com** ❑ Horizon NJ TotalCare (HMO D-SNP): **DSNP_Referrals@HorizonBlue.com** ❑ Managed Long-Term Services & Supports (MLTSS): **MLTSS_Referrals@HorizonBlue.com**

REFERRAL INFORMATION:	
Referring Facility:	
Referral Source:	

REFERRAL REASON (Please check all that apply):	
❑ Diabetes	❑ Change in condition
❑ Congestive heart failure	❑ Wound care
❑ Pneumonia	❑ Post-Acute Transitional (PAT) Care required
❑ Stroke	❑ Enrolled in Horizon NJ Total Care (HMO D-SNP)
❑ Multiple events (IP and/or ER > 3) in 3 months	❑ Psychosocial (impact ability to stay at home)
❑ Requires assistance with activities of daily living	❑ Maternity
❑ Social determination (Homeless, Placement post-acute discharge)	

Comments: _____

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