home state health™

# Case Management Referral Form

Use this form to refer a Home State Health Plan (Home State) member to our Case Management Services.

Date: _____

Member Name: _____ _____ _____ _____

MMIS ID #: _____ _____ _____ _____ _____

Member Address: _____ _____ _____ _____

Member Phone #: _____ _____ _____ _____

Provider Fax # & Contact Name: _____ _____ _____ _____ _____

Please check the reason for the referral:

☐ Non-Compliance
☐ Missed Appointments (minimum of three)
☐ High Emergency Room Usage
☐ Other (please explain):

Please give details as to the reason for the referral and your expected desired outcomes:

_____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Provider Name: _____ _____ _____ _____

Provider Phone Number: _____ _____ _____ _____

Home State Health Plan
11720 Borman Drive
Maryland Heights, MO 63146
Phone: 1-855-694-HOME (4663)
Fax: 1-877-276-8960