Health Choice
Case Management Referral Form

Please send to
Director of Case Management
HCA_CaseManagement@iasishealthcare.com
Enter priority on subject line (Routine or Urgent)
Fax (480) 317-3358

Referral Priority:
☐ Urgent (0 - 7 days) ☐ Routine (10-14 days)

Member Name: _____ Date of Birth: _____
ID Number: _____ Phone: _____
Address: _____ City: _____ Zip: _____
PCP: _____ PCP Phone: _____
PCP Address: _____ City: _____ Zip: _____

Case Management's goal is improvement in patient outcomes and satisfaction, high quality care and cost effectiveness of outpatient care, and appropriate utilization of inpatient stays.

Please check any of the following criteria:

- ☐ ER visits or admits (2+ a month)
- ☐ Chronic diagnosis or
- ☐ Behavioral / mental health
- ☐ Non-compliance with treatment / medications
- ☐ ADL / financial or social problems
- ☐ Education need

Why is member being referred to Case Management?

Diagnosis:

(HC) Person Referring: _____ Phone: _____ Date: _____
Who called HC about this referral? _____ Phone: _____

Case Management findings and follow-up notes: