Molina Healthcare of Florida, Inc.
Disease Management Referral

Section I (Section I to be completed by referral source):

Patient's diagnosis is a(n): ☐ **Existing Diagnosis** ☐ **New Diagnosis**
Program enrollment referral for: ☐ **Diabetes** ☐ **Asthma**

Date | Patient Name | DOB

SS# | Medicaid ID # | Patient Phone

Patient Address

City | State | Zip

PCP | PCP Phone

PCP Address

City | State | Zip

Product: ☐ Medicaid

Effective Date

Does the member have another Case Manager? ☐ Yes ☐ No

If yes, Agency Name

Name of Case Manager | Phone

Hospitalizations: ☐ Yes ☐ No

What dates?

Frequent ER usage: ☐ Yes ☐ No

What dates?

Comorbidities

Name of individual making referral

Title | Phone# | Fax #

SECTION II: *(To be completed by the Molina Healthcare Disease Management Program)*
Received by DM: _____Date:_____Urgent:_____Non-Urgent:_____

Return Attention to:
Molina Healthcare Corporate Disease Management
200 Oceangate, Suite 100, Long Beach CA 90802
FAX: (800) 642-3691 PHONE: (866) 891-2320