Care Coordination Member Referral

Samaritan Health Plans

Fax: **541-768-9768** | Email: carecoordinationteam@samhealth.org

Referred by: _____ Phone: _____

Referral to Care Coordination: _____ Date: _____

Member information:

First name: _____ Last name: _____

Preferred first name: _____ Pronouns: _____

Member ID: _____ Date of birth: _____

Home phone: _____ Cell phone: _____

If member is a minor, provide parent or guardian contact name and phone:

Name: _____ Phone: _____

Gender: ❑ Man or boy ❑ Woman or girl ❑ Non-binary ❑ Agender/no gender ❑ Questioning ❑ Other

Address: _____

City/state/zip: _____

Email: _____

Reason for referral ("Other" referral type description, barriers or issues affecting member):

_____

_____

Other pertinent information (Social issues, caregiver support issues, etc.):

_____

_____

Special instructions (Example: Please call provider before contacting the member):

_____

_____

Provider information:

Provider name: _____ Provider NPI: _____

Clinic name: _____ Phone: _____

Address: _____

City/state/zip: _____