# Case Management Member Referral

Samaritan Health Plans

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

Referred by: _____ Phone: _____

Referral to Case Management: _____ Date: _____

## Member information:

First name: _____ Last name: _____

Preferred name: _____ Preferred pronouns: _____

Member ID: _____ Date of birth: _____

Home phone: _____ Cell phone: _____

Gender: ☐ Male ☐ Female

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: _____