Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Florida Member (Not FEP)
Tel: (800) 955-5692
Fax: (904) 997-5188
E mail: CareMemberOutreach@bcbsfl.com

Member residence is outside Florida (Not FEP)
Tel: (800) 477-3736 ext. 69594
Fax: (904) 357-6087

Federal Employee Program (FEP)
Tel: (800) 337-2204
Fax: (904) 905-9777

Clinical Care Programs Referral Form

For referring physicians or providers

Individuals with **Complex or Chronic Health Conditions** may benefit from one of our Florida Blue Clinical Care Programs. Our nurses can assist members who have serious health problems access covered services under their health benefit plan. They also help identify community resources that may assist members and their families. This program is voluntary and offered at no additional cost to members with Florida Blue health plan coverage.

When should the physician or provider send a referral to a Clinical Care Program?
(Review appropriate Clinical Care Programs below)

Case Management	Disease Management
• When the member has complex home health care needs, such as intravenous medications and/or wound care. • When complex health issues develop. • When acute or sub-acute rehabilitative services or extensive therapy is needed. • When non-covered or out-of-contract services, such as skilled nursing facility, are needed (FEP only). *Case Management Program is for all FL members, FEP members, and FL members with residence outside the state of FL.	• When member needs help with self-management of chronic health conditions through health coaching, educational resources, and ongoing support related to treatment and preventive care. *Disease Management Program is for FL members residing within the state of FL only and FEP members.

Complete the information below and fax the completed form to the appropriate area for the member (see header above). You will be contacted by Florida Blue Clinical Care acknowledging receipt of the referral. For additional information, you may call the respective area. Information collected is protected in accordance with Florida Blue privacy and confidentiality policies and federal and state regulations. **(See page 2 to complete the form.)**

Date	Member (ID) Number	Group Number	Medicare Coverage (Check one) ☐A only ☐B only ☐ A and B
Patient Name Last	First		Date of Birth
Patient Home Phone	Patient ☐ cell / ☐business		Relationship to Policyholder (Check one) ☐Self ☐Spouse ☐Child ☐Other
Referring Physician or Provider Name	BCBSF Provider Number		National Provider Identifier (NPI)
Phone Number (Referring Physician or Provider)	Fax Number (Referring Physician or Provider)		

Description Of Medical Problems (E.g., chemotherapy, dialysis)	**In the space below, please describe current medical concerns and the assistance that you are requesting from the appropriate clinical care program.**
Diagnosis	
Physician(s) Managing Care	
Physician's Office Phone Number	
Date of Most Recent Office Visit	
Medication/Procedure	
Primary Care Physician, if applicable	