Care Management Referral Form
Florida Blue Clinical Resources

Please Forward Referral Request via Email or Fax	
You will receive confirmation of your referral no later than next business day.	
Email – CareMemberOutreach@bcbsfl.com	***Fax:*** *(904) 997-5188*
For questions or additional information, call: Phone (VM) - 844-730-2583 (844-730-BLUE)	
**Please provide your name and contact information, as well as the member's name, DOB, and member insurance card number if available.*	

Member Demographic Information – Please provide as much as known:		
Member Name (Last, First):	HCCID/ Contract #:	Preferred Telephone:
Member DOB:	Alternate Phone Number:	Preferred Call Time:
Is patient aware of this referral?	☐*YES*	☐*NO*
Did patient consent to this referral?	☐*YES*	☐*NO*

Referral Source Information:		
Referral Date:	Facility Name/Contact & Role:	Facility Contact Phone & Ext:
Anticipated or Actual Discharge Date:		Facility Contact Email:

Referral Reason and Details (REQUIRED INFORMATION)
Admission Diagnosis:
Discharge Plan: **Please attach discharge medication list to referral form**
Discharge Barriers: (i.e., transportation, caregiver support, finances, lack of resources)
Treating Provider Name:

For Internal Use Only: Intake Data	
Referral Process Date:	Florida Blue Resource:

Florida Blue Resource Action Taken:			
Date of initial attempt:	Date of engagement:	Referrals Made:	☐PHC ☐GEMD ☐Sanitas ☐DCMG Internal Resources ☐SW ☐ Pharmacy ☐ND