



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