



# Johns Hopkins US Family Health Plan (USFHP) Care Management Services Referral Form

FOR PROVIDER USE ONLY

Complete this form and fax to the Care Management department at 410-424-4885.

You will receive confirmation once processed.

Questions? Call the Clinical Screening department at 1-800-557-6916.

6704 Curtis Court  
Glen Burnie, MD 21060

*\*Required*

|                            |                                    |        |      |
|----------------------------|------------------------------------|--------|------|
| <b>Member information:</b> |                                    |        |      |
| *Date:                     | *Referring provider/ Care Manager: |        |      |
| *Member name:              | *Referring phone:                  |        |      |
| *Member ID#:               | Emergency contact:                 |        |      |
| *Member phone:             | Emergency contact phone:           |        |      |
| *Member address:           | City:                              | State: | Zip: |

**Services requested:**

**Health Promotion and Wellness**

- Health Education
- Health Coach

**Case Management Programs**

- Complex Case Management (*Peds & Adults*)
- End Stage Renal/ Integrated Renal Solutions
- Partners with Mom (*Maternity*)

**Detailed reason for referral:**

|   |             |
|---|-------------|
| <b>Care Management Services Follow-up Completed</b> |             |
| FOR INTERNAL USE ONLY                               |             |
| <input type="checkbox"/> Contact made with member   |             |
| <input type="checkbox"/> Referral forwarded to      | Department: |
| <input type="checkbox"/> Next steps                 |             |
| <input type="checkbox"/> Follow up needed           |             |
| Care Management representative:                     | Date:       |
| Notes:  |             |