Case Management Member Referral

Samaritan Health Plans

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:	

Reason for referral ("Other" referral type description, barriers or issues affecting member):

Other pertinent information (Social issues, caregiver support issues, etc.):

Special instructions (Call Health Care Guide before contacting member, etc.):

Provider information:

Name:		Provider NPI:	
Clinic name:		Phone:	
Address:			
City:	State:	ZIP:	