UPHP
UPPER PENINSULA HEALTH PLAN

Clinical Services
Care Coordination/Case Management
Referral Form

Date: _____

Referring Provider Information (Complete Sections Below as Applicable)

Provider Name: _____ Phone: ( ) _____

Clinic/Hospital Name: _____ Fax #: ( ) _____

Nurse or other contact: _____ Alt. Phone: ( ) _____

Patient Information

Name: _____

ID #: _____

DOB: _____

Home Phone: ( ) _____

Alternative Phone: ( ) _____

Diagnosis (Dx) list
(or attach problem list from record)

Primary Dx: _____

_____

_____

_____

Reason for referral: multiple co-morbidities, need for assistance with coordinating care, obtaining needed resources, patient education, etc.

_____

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_____

Plan of Care: Please attach any clinical information or other notes that would be helpful

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For questions or concerns, please contact Clinical Services at 906-225-7768
Reception at 906-225-7500 or 888-904-7526
Toll Free at 800-835-2556

Please *fax* to UPHP Clinical Services
906-225-7720

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