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: ________________________________	Diagnosis (Dx) list (or attach problem list from record)
ID #: ________________________________	Primary Dx: ______________________________
DOB: ________________________________	______________________________
Home Phone: ( ) ____________________	______________________________
Alternative Phone: ( ) ____________________	______________________________

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

____

____

____

____

____

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

____

____

____

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