TELLIGEN CASE MANAGEMENT REFERRAL

Date of Referral:

Member name:

DOB:

Medicaid number:

Member phone number:

Referring Provider/Organization Name:

Referring Provider/Organization Phone number:

Member's Primary Diagnosis:

Member's Primary Care Provider (if known):

Member's Specialist (if known/applicable):

Reason for referral:

Concerns:

Please return completed form via secure email or fax to:

CMIdaho@telligen.com

(888) 897-9003

Include any additional information that may assist in working with the member.