

Service Coordination Referral Form

Member Name:	DOB:	Referral Date:			
Insurance Plan:	Member ID Number:	COB: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Member's Current Phone Number:	POA/Guardian Name & Phone Number:	Member aware of Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referred by:	<input type="checkbox"/> BH UM <input type="checkbox"/> MS <input type="checkbox"/> BH SC <input type="checkbox"/> PA <input type="checkbox"/> Member Advocate <input type="checkbox"/> Medical UM <input type="checkbox"/> Medical SC <input type="checkbox"/> Provider <input type="checkbox"/> Medical Director <input type="checkbox"/> Other				
Concerns leading to referral: (check all that apply) <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Transplants <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Cancer (new Dx or treatment) <input type="checkbox"/> Complex/multiple surgery <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lead Exposure <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Children in Foster Care or in Foster Adoption Subsidy <input type="checkbox"/> Suicidal/Homicidal Ideation/Hx of <input type="checkbox"/> Unable to Navigate System on own <input type="checkbox"/> Court Ordered Treatment <input type="checkbox"/> Pregnancy with Serious Mental Illness/Substance Abuse <input type="checkbox"/> Kidney/liver medical complications </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Cardiovascular/Stroke complications <input type="checkbox"/> Respiratory failure/complications <input type="checkbox"/> Dementia with current complications <input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetic <input type="checkbox"/> Child w/ Special needs – Specify: Click here to enter text. <input type="checkbox"/> Anxiety Disorders <input type="checkbox"/> Member transitioning onto/off of the plan (transition of care) <input type="checkbox"/> Serious Mentally Ill Diagnosis <input type="checkbox"/> Lack of Support and/or Resources <input type="checkbox"/> Eating Disorder <input type="checkbox"/> AMA Discharge </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> TBI/Seizure disorder <input type="checkbox"/> Eating Disorder with medical complications <input type="checkbox"/> Complex Medical Treatment <input type="checkbox"/> Medical trauma/burns <input type="checkbox"/> Hepatitis <input type="checkbox"/> Pervasive Developmental Disorders <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health/Substance Abuse <input type="checkbox"/> Repeated non-compliance with Meds or Pain Tx <input type="checkbox"/> Excessive ER use <input type="checkbox"/> 2 or more IP admits within 6 months <input type="checkbox"/> Postpartum Depression </td> </tr> </table>			<input type="checkbox"/> Transplants <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Cancer (new Dx or treatment) <input type="checkbox"/> Complex/multiple surgery <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lead Exposure <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Children in Foster Care or in Foster Adoption Subsidy <input type="checkbox"/> Suicidal/Homicidal Ideation/Hx of <input type="checkbox"/> Unable to Navigate System on own <input type="checkbox"/> Court Ordered Treatment <input type="checkbox"/> Pregnancy with Serious Mental Illness/Substance Abuse <input type="checkbox"/> Kidney/liver medical complications	<input type="checkbox"/> Cardiovascular/Stroke complications <input type="checkbox"/> Respiratory failure/complications <input type="checkbox"/> Dementia with current complications <input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetic <input type="checkbox"/> Child w/ Special needs – Specify: Click here to enter text. <input type="checkbox"/> Anxiety Disorders <input type="checkbox"/> Member transitioning onto/off of the plan (transition of care) <input type="checkbox"/> Serious Mentally Ill Diagnosis <input type="checkbox"/> Lack of Support and/or Resources <input type="checkbox"/> Eating Disorder <input type="checkbox"/> AMA Discharge	<input type="checkbox"/> TBI/Seizure disorder <input type="checkbox"/> Eating Disorder with medical complications <input type="checkbox"/> Complex Medical Treatment <input type="checkbox"/> Medical trauma/burns <input type="checkbox"/> Hepatitis <input type="checkbox"/> Pervasive Developmental Disorders <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health/Substance Abuse <input type="checkbox"/> Repeated non-compliance with Meds or Pain Tx <input type="checkbox"/> Excessive ER use <input type="checkbox"/> 2 or more IP admits within 6 months <input type="checkbox"/> Postpartum Depression
<input type="checkbox"/> Transplants <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Cancer (new Dx or treatment) <input type="checkbox"/> Complex/multiple surgery <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Lead Exposure <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Children in Foster Care or in Foster Adoption Subsidy <input type="checkbox"/> Suicidal/Homicidal Ideation/Hx of <input type="checkbox"/> Unable to Navigate System on own <input type="checkbox"/> Court Ordered Treatment <input type="checkbox"/> Pregnancy with Serious Mental Illness/Substance Abuse <input type="checkbox"/> Kidney/liver medical complications	<input type="checkbox"/> Cardiovascular/Stroke complications <input type="checkbox"/> Respiratory failure/complications <input type="checkbox"/> Dementia with current complications <input type="checkbox"/> Pregnancy <input type="checkbox"/> Diabetic <input type="checkbox"/> Child w/ Special needs – Specify: Click here to enter text. <input type="checkbox"/> Anxiety Disorders <input type="checkbox"/> Member transitioning onto/off of the plan (transition of care) <input type="checkbox"/> Serious Mentally Ill Diagnosis <input type="checkbox"/> Lack of Support and/or Resources <input type="checkbox"/> Eating Disorder <input type="checkbox"/> AMA Discharge	<input type="checkbox"/> TBI/Seizure disorder <input type="checkbox"/> Eating Disorder with medical complications <input type="checkbox"/> Complex Medical Treatment <input type="checkbox"/> Medical trauma/burns <input type="checkbox"/> Hepatitis <input type="checkbox"/> Pervasive Developmental Disorders <input type="checkbox"/> Domestic Abuse <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Mental Health/Substance Abuse <input type="checkbox"/> Repeated non-compliance with Meds or Pain Tx <input type="checkbox"/> Excessive ER use <input type="checkbox"/> 2 or more IP admits within 6 months <input type="checkbox"/> Postpartum Depression			
Indicate any treatment barriers: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Housing <input type="checkbox"/> Provider availability <input type="checkbox"/> No Phone <input type="checkbox"/> Lack of Support </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Transportation <input type="checkbox"/> Physical Limitations <input type="checkbox"/> Financial <input type="checkbox"/> Other </td> </tr> </table>			<input type="checkbox"/> Housing <input type="checkbox"/> Provider availability <input type="checkbox"/> No Phone <input type="checkbox"/> Lack of Support	<input type="checkbox"/> Transportation <input type="checkbox"/> Physical Limitations <input type="checkbox"/> Financial <input type="checkbox"/> Other	
<input type="checkbox"/> Housing <input type="checkbox"/> Provider availability <input type="checkbox"/> No Phone <input type="checkbox"/> Lack of Support	<input type="checkbox"/> Transportation <input type="checkbox"/> Physical Limitations <input type="checkbox"/> Financial <input type="checkbox"/> Other				

Aetna Better Health® of Kansas
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
1-855-221-5656



Current Diagnosis if known:	
Current Medications if known:	
Important case details:	
Discharge Plan if Inpatient:	
Current PCP & Phone Number:	
Current Specialists & Phone Number:	
Referral: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied SC Name:	
Date:	SC Assigned:
Decision & Date of Notification to Referral Source:	

Email form to: AetnaBetterHealthKSCM@aetna.com or Fax to: **1-833-848-3078**