AETNA BETTER HEALTH® KIDS

Special Needs/Case Management Referral Form

Please send referrals: PACMReferralMailbox@aetna.com or fax to: 877-683-7354

All fields must be completed for processing of the referral

Date of Referral: _____ **ABH Plan Type:** CHIP **Primary COB:** UNKNOWN

Member Name: _____ **POA/Guardian/Parent Name:**_____

ABH ID: _____ **DOB:** _____ **Age/Gender:** _____

Member Address:_____ **Member County:**_____

Most recent phone number: _____ **Alternative contact phone number**_____

Primary Language:_____ **Primary Language Assessment:** Unknown

Transition of Care Alert:

- ☐ **30 Day Readmission** **# IP admits within past year:**_____
- ☐ **AMA Discharge**
- ☐ **Nursing Home Placement**
- ☐ **Excessive ER Use** **# ER visits within the past year:**_____
- ☐ **Shift Care Services Needed for Discharge (specify type):** Unknown
- ☐ **Visit Nursing Needed for Discharge**
- ☐ **Medication Reconciliation**
- ☐ **Caregiver Needs (specify):** _____
- ☐ **Lack of social supports**
- ☐ **DME Needs:** _____
- ☐ **IP Stay > 30 days**

Indicate any care coordination barriers:

☐ Housing	☐ Physical Limitations	☐ Medical Services
☐ Lack of Support	☐ Transportation	☐ Other:_____
☐ No Phone	☐ Financial	

Current Diagnosis Summary: _____

Currently Receiving BH Services: _____

Narrative:

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Concerns/Diagnosis/Population leading to Referal:

- ☐ **Diabetes**
- ☐ **Pregnancy (select type):** Not Specified
- ☐ **Sickle Cell Anemia**
- ☐ **Domestic Abuse**
- ☐ **Current NICU Admission**
- ☐ **Post NICU Admission**
- ☐ **Pediatric Shift Care Referral** Age Out (18-21 Member)
- ☐ **Neonatal Abstinence Syndrome (NAS)**
- ☐ **Substance Abuse Coordination**
- ☐ **Mental Health**
- ☐ **Behavioral Health**
- ☐ **Serious Persistent Mental Illness (SPMI)**
- ☐ **Serious Emotional Disturbance**
- ☐ **CHIP BH**
- ☐ **Lead Coordination**
- ☐ **Nerve or Brain Problems**
- ☐ **Breathing Problems (i.e. Asthma, difficulty breathing, COPD)**
- ☐ **Blood Pressure Problems (HTN, Low Blood Pressure)**
- ☐ **Cardiac Problems (Chest Pain, History of Heart Attack, CAD, CHF, Other)**
- ☐ **Transplant (specify type):**
- ☐ **Infection problems (select type):** TB
- ☐ **CG&A Referral:**_____
- ☐ **Request for Par Provider (specify):**_____
- ☐ **Cancer**
- ☐ **Child in Substitute Care**
- ☐ **Adult Protective Services Report**
- ☐ **Eating Disorder**
- ☐ **Children with Special Health Care Needs**
- ☐ **COVID-19** Unknown
- ☐ **Kidney problems (dialysis)**
- ☐ **Vision Impairment**
- ☐ **Hearing Impairment**
- ☐ **Court Ordered Treatment**
- ☐ **Autism Spectrum Disorder**
- ☐ **Bone or Joint problems (Arthritis, Amputation, Chronic Pan)**
- ☐ **Early Intervention**
- ☐ **Evaluate for Recipient Restriction Program**
- ☐ **Tobacco Abuse**
- ☐ **MANNA Request/Referral**
- ☐ **Difficulty Navigating Health Care System**
- ☐ **Linkage to BH MCO/Provider**
- ☐ **Referral to Opioid Centers for Excellence**
- ☐ **Referral to SBIRT Provider**
- ☐ **Request MAT provider**
- ☐ **Enrolled on Waiver Program**
- ☐ **MATP Coordination**
- ☐ **DME Needs:**

Referral Completed by: _____ **Contact Phone Number:** _____

Referrer Request Notification of Outcome of Referral: Not Specified