Disease Management Referral Form

All information contained on this form is strictly confidential and may become part of your patient's record.

Member information	
Member name:	Member DOB:
Member ID:	Gender: ☐Male ☐Female
Member phone:	Alternate phone:
Referring physician's name:	Referral date:
Referring physician's phone:	Referring physician's fax:

Health condition history	
☐ Asthma	☐ HIV/AIDS
☐ Bipolar disorder	☐ Hypertension
☐ Coronary artery disease	☐ Major depressive disorder — adult ☐ Major depressive disorder — child/adolescent
☐ Congestive heart failure	☐ Substance use disorder
☐ Chronic obstructive pulmonary disease	☐ Schizophrenia
☐ Diabetes Insulin dependency? ☐ Yes ☐ No	

Reason for referral

Additional comments

Please fax form back to:
Disease Management
1-888-762-3199

https://mediproviders.anthem.com/wi

AWIPEC-0953-19 August 2019