



Care Management Referral

To: *Care Management Department*

Fax: 414-847-1778 Email: caremanagement@abrihealthplan.com

From: _____ Phone: _____ Email: _____ Date: _____

Member Name: _____ Member MA ID#: _____

Case Head and/or legal guardian name (if applicable): _____

Member address: _____

Member phone number: _____

Member's PCP (if known): _____

PCP address: _____

PCP Phone number: _____

Diagnosis or Reason for Referral _____

Time Frame Requested For Reply: _____

INSTRUCTIONS:

You may e-mail this form to caremanagement@abrihealthplan.com PASSWORD PROTECTED OR ENCRYPTED or you may FAX it to 414-847-1778. You will receive a response informing you of the status of your referral. If this member is accepted for care management, you will receive the name and phone number of the Care Manager working with this member.

PLEASE NOTE** If this is an EMERGENCY, i.e., you need to speak to someone right away, please call Abri Customer Service @ 414-847-1776. DO NOT FILL OUT THIS FORM. Customer Service can connect you to someone from the Care Management Department right away.**