

Care Management Referral Form



WellSense Health Plan offers a variety of care management programs to members with complex medical or behavioral health conditions, or other barriers to health. Please complete this form to recommend your patient for Care Management. We will notify you via email of the program that best fits your patient's needs.

Member Information

Member Name		DOB	Gender
WellSense ID #	Medicaid ID #		
Home phone		Cell phone	
Address			
Legal guardian name		Legal guardian phone number	

Referring Provider Information

Referring provider name		<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Other _____	
Referring provider/group name /			
Email	Phone	Fax	

State or community agency involvement:

Care Management Referral Reason

Reason for Referral (check all that apply): <input type="checkbox"/> Multiple recent hospitalizations <input type="checkbox"/> Multiple ED visits <input type="checkbox"/> Complex behavioral health/SUD needs <input type="checkbox"/> Complex medical needs <input type="checkbox"/> Special needs <input type="checkbox"/> 2+ chronic conditions under poor control <input type="checkbox"/> Need functional assistance with ADLs/IADLs <input type="checkbox"/> High risk pregnancy <input type="checkbox"/> Other _____	Diagnoses (check all that apply): <input type="checkbox"/> Serious and Persistent Mental Illness (SPMI) <input type="checkbox"/> Substance Use Disorder (SUD) <input type="checkbox"/> Diabetes <input type="checkbox"/> Asthma <input type="checkbox"/> Heart failure <input type="checkbox"/> Other _____	Socioeconomic barriers (check all that apply): <input type="checkbox"/> Homelessness <input type="checkbox"/> Housing insecurity <input type="checkbox"/> Food insecurity <input type="checkbox"/> Lack of social supports <input type="checkbox"/> Frequent missed or canceled appointments <input type="checkbox"/> Other SDOH needs _____
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Add pertinent clinical and psychosocial information to assist with triage to appropriate program (e.g. specific diagnosis, social determinants of health, recent admits, and/or current presentation/goals):

Preferred Care Management Program	Submit to:
<input type="checkbox"/> Massachusetts Care Management (includes medical, social, maternal child health)	CM.Tel@wellsense.org or fax 617-951-3426
<input type="checkbox"/> New Hampshire Care Management (includes medical, social, maternal child health)	NHCare.Management@wellsense.org or fax 866-409-5657
<input type="checkbox"/> Behavioral Health Care Management (includes BH and SUD)	BHCMReferrals@wellsense.org
<input type="checkbox"/> Massachusetts BH Community Partner	BHCP@wellsense.org
<input type="checkbox"/> Massachusetts LTSS Community Partner	LTSSCP@wellsense.org