Referral Form to Care and Disease Management Programs

Send form via secure email to: CareSupport@medica.com
Or fax to: 1-952-992-3589
Member eligibility will be determined in 4-6 business days. Member will receive a call if eligible for program.

**Indicates required field*

Date: ______________

A TYPE OF REFERRAL

❍ **Complex Case Management**

❍ **Disease Management**
- ❍ Asthma
- ❍ Cardiac Disease
- ❍ Diabetes
- ❍ Weight Management (MSHO only)

❍ **Tobacco Cessation**

B REFERRAL FROM

Name:	Organization	
Phone:	Email:	Fax:

C MEMBER INFORMATION

*First name:	*Last name:	*DOB:

*Address 1:

Address 2:

*City:	*State:	*County:	*ZIP:

*Telephone:	Best Time to Call: ❍ 8am-11am ❍ 11am-2pm ❍ 2pm-4pm ❍ 4pm-6pm
*Member ID#:	*Medica Product:

*Primary Language:

❍ English ❍ Hmong ❍ Russian ❍ Somali ❍ Spanish ❍ Other:_____________

D REASON FOR REFERRAL

Include helpful things to know about member (e.g. cognitive, behavioral or socioeconomic factors):