Medica

Medica Behavioral Health Targeted Case Management Request Form

(Please have TCM provider complete this form)

Client Name:_____ **DOB:**_____ **PMI#:** _____

Client Address: _____

Client Phone #: _____

TCM Provider: _____

Provider Address: _____

_____

Agency/County: _____

AUTHORIZATION START DATE: _____

Current Diagnosis

DSM5: _____

Date of Last Annual Wellness Physical: _____
If unknown, please obtain this information from the member.

Does the member have any of the following medical issues?

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Cancer
- ☐ Hypertension
- ☐ Asthma
- ☐ Rheumatoid Arthritis
- ☐ Chronic Pain
- ☐ Other _____

Does the member have unmet or complex medical needs? Yes ☐ No ☐

If yes, please explain: _____

If yes, do you have the necessary resources to assist them with this? Yes ☐ No ☐

Would it be helpful to receive a call from a TCM Care Advocate to assist with medical or behavioral resources (e.g. durable medical equipment such as a walker or diabetic supplies, or a day treatment program or new psychiatrist)? Yes ☐ No ☐

Have they been hospitalized (behavioral or medical reasons) within the past 6 months? Yes ☐ No ☐

If yes, for what were they hospitalized? _____

Have they had a change in their commitment status? Yes ☐ No ☐

** Complete the LOCUS/CASI within 30 days of start of TCM.*

Fax completed form to: Medica Behavioral Health 1/855-454-8155

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