

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?

- | | | | |
|--------------------------------|--|------------------------------------|------------------------------------|
| <input type="radio"/> Diabetes | <input type="radio"/> Heart Disease | <input type="radio"/> Cancer | <input type="radio"/> Hypertension |
| <input type="radio"/> Asthma | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Chronic Pain | <input type="radio"/> 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

**P.O. Box 1459 ☞ MN103-0500 ☞ Minneapolis, MN 55440-1459
Intake: (800) 848-8327 ☞ Fax: 1/855-454-8155**