

# Massachusetts 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’s legal name		DOB	Gender
Member’s preferred name		Preferred language	Pronouns
WellSense ID #	Medicaid ID #		ACO name
Primary phone		Are they new to the U.S.? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Are they new to Massachusetts? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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:	<input type="checkbox"/> DMH <input type="checkbox"/> DDS	<input type="checkbox"/> DCF <input type="checkbox"/> Mass Ability	<input type="checkbox"/> CBHI <input type="checkbox"/> Other _____

## Care Management referral reason

<p><b>Reason for referral</b> (check all that apply):</p> <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 _____	<p><b>Diagnoses</b> (check all that apply):</p> <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 _____	<p><b>Socioeconomic barriers</b> (check all that apply):</p> <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"/> Transportation issues <input type="checkbox"/> Other SDOH needs
--	--	---

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** (If unknown, check the first box)**Submit to:** ACO Care Management (includes medical, social, maternal child health)[ACOCMReferral@wellsense.org](mailto:ACOCMReferral@wellsense.org)  
or fax 857-366-7800 Behavioral Health Care Management (includes BH and SUD)[BHCMLReferrals@wellsense.org](mailto:BHCMLReferrals@wellsense.org) MA Care Management (includes medical, social, maternal child health)[CM.Tel@wellsense.org](mailto:CM.Tel@wellsense.org)  
or fax 617-951-3426