ACO 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 #	ACO name
Home phone	Cell phone	
Address		
Legal guardian name	Legal guardian phone number	

Referring Provider Information

Referring provider name	☐ PCP ☐ Specialist ☐ Other___________		
Referring provider/group name	/		
Email	Phone	Fax	
State or community agency involvement:	☐DMH ☐DDS	☐DCF ☐Mass Rehab	☐ CBHI ☐ Other ___________

Care Management Referral Reason

Reason for Referral (check all that apply):	**Diagnoses** (check all that apply):	**Socioeconomic barriers** (check all that apply):
☐Multiple recent hospitalizations ☐Multiple ED visits ☐Complex behavioral health/SUD needs ☐Complex medical needs ☐Special needs ☐2+ chronic conditions under poor control ☐Need functional assistance with ADLs/IADLs ☐High risk pregnancy ☐Other ___________	☐Serious and Persistent Mental Illness (SPMI) ☐Substance Use Disorder (SUD) ☐Diabetes ☐Asthma ☐Heart failure ☐Other ___________	☐Homelessness ☐Housing insecurity ☐Food insecurity ☐Lack of social supports ☐Frequent missed or canceled appointments ☐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 **or fax 857-366-7800**
☐ ACO Behavioral Health Care Management (includes BH and SUD)	BHCMReferrals@wellsense.org
☐ BH Community Partner	BHCP@wellsense.org
☐ LTSS Community Partner	LTSSCP@wellsense.org