SOLIS HEALTH PLANS

CASE MANAGEMENT REFERRAL FORM

As a provider caring for Solis Health Plans membership, you may identify members who could benefit from Case Management Services. Through the Case Management Services offered by Solis, a Registered Nurse, Social Worker, or Care Coordinator engages the member and performs an assessment of the member's physical, behavioral, psychosocial, and pharmaceutical components. Once assessed, the appropriate Solis staff member coordinates resources and establishes communication with the member as well as the involved providers to facilitate quality care, assist with navigation of services and benefits, and ultimately work alongside the primary practitioner's office to maintain the member as healthy as possible.

Solis Case Manager can:	Members who might benefit:
Answer questions that may come up between doctor visits about health conditions and medicine	Have chronic conditions
Coordinate medication and care among providers	Member with multiple conditions such as Diabetes and cardiovascular disease
Assist with health plan services and accessing benefits	Are frequently hospitalized
Help locate community resources such as transportation, meals, housing, financial and social services	Have a psychiatric or behavioral health condition
Navigate between multiple payers (Medicaid and LTSS)	Have limited family support

Potential Case Management members must reside in Solis' service area, be actively enrolled as a Solis Health Plans member, and agree to participate in the case management service. Participation is voluntary and the member is able to opt out of the case management program whenever they desire.

To be Completed by Provider

PROVIDER INFORMATION			
Provider Name (Print):		Credential: MD, DO, NP, PA	
Provider Office Tel #:		**Provider Fax #:**	
MEMBER INFORMATION			
Member Name:		**Gender:**	☐M ☐ F
Member Plan ID #:		**DOB:**	
Member Address:			
	City:	**FL**	**Zip Code:**
County:	☐Miami-Dade ☐Broward ☐ Palm Beach ☐Orange ☐Hillsborough		
Phone #:		**Alternate Phone #:**	
Principle Diagnosis:			
Provider Signature:		**Date:**	

Instructions:

☐ Fill in all sections of the form ☐ Sign and Date form

☐Fax completed form to: 1-833-615-9261

or

☐ email to: CaseManagementCoordinators@SolisHealthPlans.com