SoonerCare

CARE COORDINATION REFERRAL FORM

PHONE 1-877-252-6002 | FAX 1-405-530-3217

Referral by: _____ Phone: _____ Referral date: _____

REFERRAL SOURCE

- ☐ Primary Care Provider
- ☐ Emergency Department
- ☐ Community Agency
- ☐ Other
- ☐ Specialty Provider
- ☐ Caseworker/DC planner
- ☐ Transition Coordinator

MEMBER INFORMATION

Member Name: _____ Member ID: _____

Member DOB: _____ Member Phone: _____

Contact Name: _____ Contact Phone: _____

Relationship to Member: ☐ Self ☐ Family ☐ Other (specify): _____

REASON FOR REFERRAL

- ☐ Member has chronic health issues such as diabetes, high blood pressure, heart disease, arthritis, or Sickle Cell Disease
- ☐ Request for Out of State services, meals and/ or lodging assistance for in/ out of state care, or non-SoonerRide transportation needs
- ☐ At risk newborn or child with special needs
- ☐ Medication review needed (e.g. adult members with 4+ chronic meds OR 1 hospitalization in the past year)
- ☐ Member is pregnant, experiencing at-risk or high-risk pregnancy
- ☐ Community resources needed
- ☐ High Emergency Department utilization
- ☐ Other(please specify) _____

PLEASE DESCRIBE CONCERNS, REASONS FOR REFERRAL, AND ATTACH RELEVANT MEDICAL RECORDS. ATTACHING RELEVANT MEDICAL RECORDS WILL EXPEDITE CARE COORDINATION PROCESS.

INCOMPLETE FORMS WILL BE RETURNED

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/ohca
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

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