BlueCross BlueShield of Texas

TEXAS Health and Human Services
Case Management for Children and Pregnant Women

Children and Pregnant Women (CPW)
Referral and Intake Form

CM- 01A
4/18

REFERRAL		
Referral Date:	**Name of Referral Source (List agency/company name):**	**Name of Person Making Referral:**
Phone Number for Person Making Referral:	**Fax Number for Person Making Referral:**	

CLIENT INFORMATION			
Client Name:	**DOB:**	☐ **Male** ☐ **Female**	
Medicaid #:	**Language Preference:**		
Parent/Guardian Name (if client is under 18):			
Residential Address:	**City:**	**ZIP:**	**County:**
Phone Numbers: **Home:**	**Work:**	**Cell:**	**Other:**
Health Condition/Health Risk (Child) or High-Risk Condition (Pregnant Woman) / Case Management Needs Per Referral Source:			
Referral section completed by:			
Priority Status of Referral: ☐ **Urgent (contact within 1 working day)** ☐ **Standard (contact within 7 working days)**			

INTAKE (completed by case manager with client/parent/guardian)	
Date of Intake:	**Information provided by:**
☐ **Information same as provided by referral source**	
☐ **Additional information provided by client/parent/guardian; Include expected date of delivery if pregnant:**	

Outcome of Referral:

- ☐ **Eligible needs. Submit initial prior authorization request for case management services.**
- ☐ **Routine medical and dental needs. Refer to Texas Health Steps Hotline or MCO.**
- ☐ **Routine medical transportation needs. Refer to Medical Transportation Program.**
- ☐ **Basic needs only. Refer to 2-1-1 or other community resource.**
- ☐ **Not interested in case management services and/or no needs identified.**
- ☐ **Other**

Attempts to Contact Client/Parent/Guardian

Date of Attempts:	Action:
1.	
2.	
3.	
Intake completed by:	