Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Member Case Management Application Form

Form to be completed by person referring themselves to Case Management, Continuity of Care or Care Coordination.

Member name: _____Member date of birth: _____

Member phone number: _____Certificate number: _____

Name of person submitting form (if other than member): _____

Referrer phone number: _____ Date applied for Case Management: _____

Reason for Case Management application

☐ **High-risk obstetrics — gestational age less than 35 weeks**

- ☐ Pregnancy-induced high blood pressure
- ☐ Have diabetes requiring insulin
- ☐ Previous preterm labor — baby born less than 35 weeks for two or more pregnancies
- ☐ Confirmed social struggles (domestic abuse, depression) with plans to continue pregnancy
- ☐ Obese with a body mass index (BMI) greater than 35
- ☐ Current substance abuse (including smoking or using alcohol) — type: _____
- ☐ Cervix issues ☐ Cerclage (date performed): _____
- ☐ Placenta issues
- ☐ Severe nausea and vomiting with weight loss of 10 pounds or more during pregnancy
- ☐ Other (specify high-risk condition): _____

☐ **Transplant**

- ☐ Type:_____

☐ **Catastrophic conditions (adult or child)**

- ☐ Catastrophic or complex diagnosis requiring coordination of care, connection to services, and/or coordination of benefits
- ☐ Multiple social struggles (domestic abuse, food, transportation) causing barriers to proper care
- ☐ Chronic conditions that have caused:
  - ☐ Three or more hospitalizations within the past six months
  - ☐ A nonhealing wound requiring active treatment for a duration greater than three months

☐ **End-stage kidney disease**

- ☐ Hemodialysis
- ☐ Peritoneal dialysis

☐ **HIV/AIDS**

- ☐ HIV
- ☐ AIDS

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Continuity of Care services (insurance changed or doctor's contract was terminated)

Do you have a need for continuation of services? _____

☐ Acute or chronic health care condition requiring continuity of care to complete a course of treatment

☐ Terminal illness ☐ Pregnancy

☐ Surgery ☐ Newborn (birth to 36 months)

☐ Additional information or comments: _____

Care Coordination (Please check the box beside any that might apply to you.)

☐ Don't always take your medicine as prescribed ☐ Don't follow your treatment plan

☐ Need behavioral health assistance or services ☐ Feel you have a gap in your care

☐ Don't always make it to your appointments or follow-up care ☐ Have been to the ER frequently

☐ Don't understand your plan's benefits ☐ Have a problem abusing drugs

☐ Need help finding a specialty provider ☐ Other: _____

☐ Additional information or comments:

_____

_____

What do you think Case Management can do to help you get better health care?

_____

_____

_____

Are medical records attached to this application? ☐ Yes ☐ No