

**CareSmart Disease Management Programs**

Fax Completed Form to: 1 800-421-2885  
For information about the program, call: 1-888-416-3025

Disease Specific Education (Check one):     CAD     COPD     Asthma     Diabetes     Heart Failure

Date of Referral:

Place of Referral: (*check one*):     PCP Office     Specialist     ER     Other

Referring Provider: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Tennessee Medicaid Number: \_\_\_\_\_ National Provider Identifier: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Preferred Education:     Home Health     Public Health Dept     Pharmacy

Preferred Location:     PCP Office     Hospital-based     No Preference

Member Name: \_\_\_\_\_, \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone/Other: \_\_\_\_\_

Current Member Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Additional Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_ Work/Other Phone: \_\_\_\_\_

Primary Diagnosis and ICD9 Code(s): \_\_\_\_\_

Reference number: \_\_\_\_\_     Initial request     Subsequent request

Number of visits: \_\_\_\_\_

Dates of service: \_\_\_\_\_ - \_\_\_\_\_

Disease Management Specialist: \_\_\_\_\_ Ext: \_\_\_\_\_

