

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: _____

Member Name: _____

Identification number: _____

Diagnostic/Screening Test Results

	Test	Date	Result
	Fasting Blood Glucose		
	HgbA1C		
	Micro albumin		
	Cholesterol, LDL, HDL		
	Left Ventricular Ejection Fraction		
	Last Chest X-ray		
	Echo Cardiogram		
	Pulmonary Function Test		
	Peak Flow Ranges		
	Allergy Testing		

Physician's Orders

 Disease Specific Education: CAD COPD Asthma Diabetes Heart Failure

Referral Information (Please Print)

 Provider Signature

 Date

 Provider Name (Please Print)