Amerigroup RealSolutions in healthcare

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Disease Management Referral Form

All information contained on this form is strictly confidential and may become part of your patient's record.

Member's information	
Member's name:	Member's DOB:
Member's ID:	Gender: ☐Male ☐Female
Member's phone:	Alternate phone:
Referring physician's name:	Referral date:
Referring physician's phone:	Fax:

Health condition history	
☐ Asthma	☐ HIV/AIDS
☐ Bipolar disorder	☐ Hypertension
☐ Coronary artery disease	☐ Major depressive disorder
☐ Congestive heart failure	☐ Substance use disorder
☐ Chronic obstructive pulmonary disease	☐ Alzheimer's/dementia (program only available in Florida) If yes, please provide caregiver's name and phone:
☐ Diabetes	
☐ Insulin dependency	

Reason for referral

Additional comments

Please fax form back to:
Disease Management Centralized Care Unit
1-888-762-3199 or 757-955-8891