Request for Medically Frail Assessment

Date:_____ Referring Facility: _____

Provider/Contact Person Phone:_____

Member Name:_____ Member RID: _____

Date of Birth:_____ Member Phone Number(s): _____

Diagnoses With Dates: _____

_____

_____

Inpatient Hospitalizations (Dates and Diagnoses): _____

_____

_____

Medications: _____

_____

_____

Current Treatment Plan: _____

_____

_____

Supporting Documentation Included:

__ Intake Assessment (initial evaluation)

__ Intake Assessment (medical)

__ History & Physical

__ Psychosocial (if not included in initial evaluation)

Please fax to CareSource Medically Frail Department at 937-487-0131
Attn: Medically Frail Care Manager.
HIP 0222 (5/19)

IN-P-0331c
Date Issued: 01/15/2020 Date Approved: 01/08/2020