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: _____

_____

_____

Please Describe Member's Current Treatment Plan:

_____

_____

_____

Supporting Documentation Included:

__ Intake Assessment (initial evaluation)

__ Intake Assessment (medical)

__ Medical History & Physical

__ Psychosocial (if not included in initial evaluation)

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