PROVIDER REFERRAL FOR MEMBER EDUCATION

We encourage you to make referrals directly to CareSource based upon your professional judgment that the CareSource member would benefit from education in the areas specified below.

Referral Information:

Member Last Name:
Member First Name:
Member Address:
Phone:
Email:
Date of Birth:

Provider Information:

Name:
Title:
Group (if applicable):
Address:
Phone:
Email:
Date of Referral:

Educational Areas:

☐ Importance of adherence to scheduled appointments
☐ Importance of medication adherence
☐ Access to healthcare; appropriate use of emergency department resources
☐ Importance of practicing good behavior while in provider's office
☐ Other: _____

Send completed forms to IndianaOutboundTeam@CareSource.com or fax to 937-487-1478.