MBHP
Massachusetts Behavioral Health Partnership
A Carelon Behavioral Health Company

MassHealth PCC Plan

Fax:
1-855-895-9758

MBHP Integrated Care Management Program (ICMP) Referral Form

Date: _____ Enrollee name: _____

Address (required field): _____ Town: _____ Zip code: _____

Phone # (required field): _____ DOB: _____ Gender: _____

MassHealth Member ID #: _____ (*if not available, please provide SS#)* _____

Legal guardian/custody: _____ Cultural background: _____

Language: _____ Where is Enrollee now? (e.g., home, my office, other): _____

Referred by (name/title): _____ Agency/Dept./Phone: _____

If known, list the agency/agencies involved in the Member's care below:

Agency/Provider Name	Contact Person Name	Region (or N/A)	Phone Number
Primary care clinician			
Outpatient therapist			
Specialist			
Psychiatrist			
State agency (circle all applicable): DMH, DCF, DYS, DDS			

Reason for Referral: Please check appropriate box below.

- ☐ Medical
- ☐ Behavioral health
- ☐ Combination (medical and behavioral health)

Provide a brief explanation of the referral reason including potential goals for Care Management:

_____

_____

_____

_____

_____

PCC PRACTICES ONLY: COMPLETE BELOW IF YOU OPERATE YOUR OWN CARE MANAGEMENT PROGRAM.

Select one or more referral reason, as applicable:

- ☐ Complexity of mental health condition(s)
- ☐ Complexity of both medical and mental health condition(s)
- ☐ I believe the Member needs face-to-face visits in the community; I'm unable to do so. (If you checked this, please provide the reason/rationale for the Member needing face-to-face visits.)

_____

Please attach a separate page with any additional information regarding this referral.

Fax completed referral to the ICMP at 1-855-895-9758 or call 1-800-495-0086, Ext. 706870 with questions.

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