CARE COORDINATION NOTIFICATION FORM

FAX TO: 915-225-1174
Phone: 1-888-532-3778
E-Mail: **preferredadmin@elpasohealth.com**
Address: 1145 Westmoreland, El Paso, TX 79925

Use this form to refer TPA member to CARE Solutions Department. Please complete all fields.

Submitted Date:	Referring Provider Name:	
Phone: Fax:	Contact Person:	

Member Information

Member Name: (Last, First M.I.)	Address:	
Health Plan ID#:	DOB:	Phone:

Provider Information (if applicable)

Primary Care Provider:	Provider Address	Phone Number
Specialist: Type of Specialist:		
Behavioral Health Provider:		
Hospital:		
Other Provider:		

Reason for Notification to Care Coordination (check "✓" all that apply)

Care Coordination

- ☐ Two or more inpatient admissions within the last year
- ☐ Second Opinion Visit
- ☐ Continuation of Treatment
- ☐ Specialist not available in member's area
- ☐ Significant impairment in two or more activities of daily living, particularly when there are inadequate support systems (e.g., trauma, brain injury, burns)
- ☐ Needs help with coordination of medical services
- ☐ Treatment of available in El Paso Region Area
- ☐ Post-Transplant recipient
- ☐ New Hemodialysis

Other (please specify)

☐ _____

Diagnosis/Medical History

- ☐ Cancer
- ☐ Organ Transplant
- ☐ Neuro
- ☐ Behavioral
- ☐ Other: _____

Diagnoses: (list any pertinent that you would like us to address)

_____

_____

Brief Description of Notification Need *For Preferred Administrators Only*

NOTE: Member agreed to be referred for case management. Yes or No