

Referral and Transition of Care Request

If you have questions about BlueSalud member coverage, call Customer Service at 1-866-689-1523.

Fax this completed form to 1-505-816-3608.

Patient is a (please check one):

BlueSalud member

This is a request for (please check one):

Case Management
 Care Coordination
 Behavioral Health
 Special Needs
 Transition of Care

Patient name:	BCBSNM ID# or SS#:	Date of birth:
Address:	City:	Zip:
Name of parent/guardian (if patient is under 18 years of age):	Phone number:	
Name of primary care provider:	Phone number:	

Waiver program(s) (check all that apply):

- Developmental Disability
 Medically Fragile
 Coordination of Long-Term Services
 Children <3 years
 Pregnant Women & Infants
 Juvenile Justice
 Adult & Child Protective Services
 Other
 HIV/AIDS
 Traumatic Brain Injury
 Early Prevention & Screening Diagnostic Treatment

Referral date:	Referral source:	Phone:
Reason for referral/current issues:		
Medical diagnosis(es):		
Behavioral diagnosis(es):		
Treatment plan:		
Expected completion date:	Provider's signature:	
Currently receiving case management services: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact name & phone:	
Special education student: <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently enrolled in: <input type="checkbox"/> IEP <input type="checkbox"/> IFSP	
School:	School contact name:	
Currently seeing a mental health professional: <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact name & phone:	
Requires a mental health referral: <input type="checkbox"/> Yes <input type="checkbox"/> No		

This section is to be completed by BlueSalud staff	
Received by (CC/CM Supervisor) _____	Date received _____
Member eligibility verified: Yes <input type="checkbox"/> No <input type="checkbox"/>	BlueSalud: Yes <input type="checkbox"/> No <input type="checkbox"/>
Assigned to _____	Date assigned _____

BlueSalud services are funded pursuant to an Agreement with the State of New Mexico.