Health Access Network
Case Management Program

PROVIDER REFERRAL FORM

MEMBER NAME	
DATE OF BIRTH	
MEDICAID ID NUMBER	
PROVIDER NAME	

DEAR PROVIDER:

- REASON FOR CASE MANAGEMENT REFERRAL:
  _____
  _____
  _____

SOONER CARE ENROLLMENT EFFECTIVE DATE :_____
(if known)

- CLINIC STAFF PROVIDING REFERRAL:_____
  CONTACT #: _____

Please contact OSU HAN main office # for questions, concerns or to request specific education/interventions regarding Case Management Services at 918-561-1155. You may submit this referral form via fax at 918-561-1218 or e-mail to osuhan@okstate.edu.
Provider Handbook available upon request.

Completed by OSU HAN Case Manager:_____Date:_____