SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Targeted Case Management Referral

Beneficiary Information

Beneficiary Name: _____ _____ _____
Last *First* *M.I.*

Beneficiary Date of Birth: _____ Medicaid ID: _____ Date of Referral: _____

Beneficiary Phone Number: _____ Beneficiary Email: _____

Parent/Guardian Name (If Applicable): *Last* _____ *First* _____

Diagnosis Code/s: _____

Referral Instructions

(1) Complete sections 1, 2, and 3 of the form.
(2) The Referral Form is only valid for 90 days. If a member requires services beyond 90 days, submit a new Referral Form prior to the referral end date.

1. Referral Source Information:

Provider/agency name: _____
Address: _____
Phone number: _____
TIN: _____ NPI: _____

Name of person completing form: _____
Contact information: _____ _____
Phone *E-mail*

2. Referral Indicators:

Note which areas require attention (Choose as many as applicable).

☐ Medical ☐ Social ☐ Psychosocial ☐ Educational ☐ Vocational

☐ Financial ☐ Housing ☐ Transportation ☐ Food Insecurity ☐ Other

Briefly describe the reason for referral for each indicator chosen above:

3. Referrer Signature:

I attest that the information on this form is true and accurate to the best of my knowledge.

Printed name	Signature	Date