Care Management Request

VA Premier Health Plan, Inc.

Contact Type (select one)		
Member Name First Last Suffix:	Date of Birth / /	Member ID #:
Member Address Addr1: Addr2: City: State Zip:	Member Phone #:	
Diagnosis:		
Reason for Referral:		
Name of Referring Provider First Last		
Provider Address Addr1: Addr2: City: State Zip:		
Program Referral: **(please check applicable program(s))**		
☐ Case Management		
☐ Disease Management	☐ Asthma ☐ Bipolar Disorder ☐ Childhood Weight Management ☐ COPD ☐ Diabetes ☐ Heart Disease ☐ Schizophrenia	

Please fax this form to: 1-800-827-7192