OHCA Approved 04/30/2019

SoonerCare
Oklahoma Health Care Authority

Care Coordination Referral Form

Phone 1-877-252-6002
Fax 1-405-530-3217

Referral by: _____ Phone: _____ Referral date: _____

Referral Source

- ☐ Primary Care Provider
- ☐ Specialty Provider
- ☐ Emergency Department
- ☐ Other
- ☐ Caseworker/DC planner
- ☐ Community Agency
- ☐ Transition Coordinator

Member Information

Member Name _____ Member ID _____

Member DOB _____ Member Phone _____

Contact Name _____ Contact Phone _____

Relationship to Member (circle) Self Family Other (specify): _____

Reason for Referral

- ☐ Member has chronic health issues such as diabetes, high blood pressure, heart disease, arthritis, or Sickle Cell Disease
- ☐ Request for Out of State services, meals and/or lodging assistance for in/out of state care, or non-SoonerRide transportation needs
- ☐ At risk newborn or child with special needs
- ☐ Member is pregnant, experiencing at-risk or high-risk pregnancy
- ☐ Community resources needed
- ☐ High Emergency Department utilization
- ☐ Other (specify): _____

Please describe concerns, reasons for referral, and attach relevant medical records.
Attaching relevant medical records will expedite care coordination process.

INCOMPLETE FORMS WILL BE RETURNED

4345 N Lincoln Blvd. OKC | 405-522-7300 | okhca.org