MemberConnections® Provider Referral Form

Use this form to refer an IlliniCare Health member for a MemberConnections® outreach phone call and in-person home visit.

Fax the completed form to 1-877-668-2075.

Date:

MEMBER INFORMATION

First Name: ______________________________

Last Name: ______________________________

Member ID: ______________________________

Date of Birth: ______________________________

Address: ______________________________

City, State: ______________________________

Phone: ______________________________

PROVIDER INFORMATION

Provider Name: ______________________________

Clinic/Agency: ______________________________

Phone: ____________________ FAX: ____________________

Contact for Follow-Up: ______________________________

PLEASE SELECT REASON FOR REFERRAL

- ☐ Missed Appointments (minimum of 3 missed appointments)
- ☐ Medications Not Picked Up
  - Date: ______________________________
  - Type of Medicine: ______________________________
- ☐ High Emergency Room Use
- ☐ Post In-Patient Discharge Follow-Up
- ☐ Other – Please Explain:

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Comments:

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- ► A MemberConnections® Representative will make an outreach phone call and attempt a home visit for this referred member. This process may take up to 2 weeks.
- ► IlliniCare Health will send a faxed follow-up to the Referring Provider with the outcome of the outreach phone call and home visit attempt.