silversummit healthplan

Mental Health and Substance Use
Care Management Program Referral Form

Use this form to refer a member whom you assess as CM eligible. Silversummit will assess the member's eligibility and respond with next steps or request more information within one week. ***Asterisk (*) identifies required information field.***

Please submit via secure fax (Fax Number: 844-851-1023)

REFERRAL SOURCE INFORMATION	
Date of Request:	
Referring individual name: *	
Referring organization name: *	
Referrer phone number: *	( )
Has the member expressed interest in opting into CM?	☐ Yes, I have already discussed the program with the member. Comments: ☐ No

MEMBER INFORMATION			
Member name: *		Member DOB: *	
Member ID number: *		Parent/Guardian Name (if applicable):	
Member address:			
Member primary phone number: *		Member email address:	
Member preferred language:			
Is member currently Pregnant?	☐ Yes If yes, Estimated Date of Confinement (EDC): _____ ☐ No		

REASON FOR REFERRAL (Check all that apply): *	
☐	Individual experiencing **Behavioral Health (BH/MH)** concern
☐	Individual reports **Substance/Alcohol Use Disorder** concern

ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____