MedStar Family Choice

Please return via fax at 410-933-2209.

Case Management Referral Form

Date: ____________________________

Provider name: ___________________________ Contact number: ___________________

MFC member name: ___________________________ Date of birth: __________________

Member's current address: ____

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Member's current phone number: ____

Is the member agreeable to a Case Management follow up call? Yes ☐ No ☐

Clinicals attached: Yes ☐ No ☐

Additional information:____

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It's how we treat people.