



## Indiana *Care Select* Disease Management Program

### Provider Referral Form

<i>Member Name</i>	
<i>Member RID</i>	
<i>Member Contact Number</i>	
<i>Provider Name</i>	
<i>Provider ID</i>	
<i>Provider Contact Number</i>	
<i>Provider Signature</i>	

Chronic Condition and/or Disease – Please check all that apply.

- Asthma
- Diabetes
- Heart Failure
- Congestive Heart Failure
- Hypertensive Heart Disease
- Hypertensive Heart and Kidney Disease
- Rheumatic Heart Illness
- Severe Mental Illness
- Serious Emotional Disturbance (SED)
- Depression

Please note that a referral does not guarantee participation in the *Care Select* program. The individual must also meet other qualifying criteria in addition to one or more of the covered conditions. In addition, the *Care Select* program is voluntary and the individual may decide whether to participate. They can choose to opt in or out of the program at any time.

Questions may be directed to the *Care Select* Helpline at 1.866.963.7383.

**Fax the completed form to the *Care Select* Program at 317.238.3120.**