

**Wyoming Healthy Together Wyoming Medicaid
Health Management Referral Form**



Please complete the referral information below and fax it to **1-888-245-1928**, or you can call **1-888-545-1710**.
Client information is kept confidential.

PAY FOR PARTICIPATION (P4P)

Wyoming Healthy Together Client (Patient)

Name: _____
 Address: _____

 City: _____
 State: _____ Zip: _____
 Phone Number(s): _____
 DOB: _____
 Parent or Guardian Name: _____

 Medicaid Number: _____
 Primary DX: _____

Reason for referral to program:

- Client needs education (disease, treatment plan)
- Reinforce medication and/or treatment compliance
- Provide links to community resources
- Assist coordination of care and/or services
- Weight Management program
- Language, literacy barrier
- Missed appointment(s)
- Maternal/Prenatal support:
 EDC ___ Grav ___ Para ___
- Other: _____

Provider Information

Name: _____
 Referring staff name: _____
 Office: _____
 Address: _____

 Phone: _____
 Fax: _____
 Primary Care Physician: _____
 Primary Mental Health Provider (if applicable):

Follow-up instructions for Healthy Together Staff

I would like clinical updates:

- Patient information (progress notes after each contact)
- When there are changes or concerns
- Other special follow-up information requested:

Wyoming Healthy Together use only

C3#: _____ REG: _____ TLVL: _____ CC: **Y - N** HC: _____ RPT: **Y - N** EP TYPE: **NEW - EXIS**
 DX(s): _____ | _____ | _____
 Date Received: _____ Opened: _____ F/U REQ: **Y - N**