Exhibit 5.1

Case Management Referral Form

Return Response: _____ Medicaid URGENT(24hr) _____ Medicaid ROUTINE(3 Days)

_____ Medicare URGENT(3 Days) _____ Medicare ROUTINE(7 Days)

Member Name: _____ Date of Birth: _____

ID Number: _____ Phone: _____

Address: _____ City_____ Zip_____

PCP: _____ PCP Phone: _____

PCP Address: _____ City_____ Zip_____

Referred By: _____ Title/Position: _____

Contact Phone: _____ E-Mail: _____

Case Management's goal is quality and cost effectiveness of outpatient care, appropriate utilization of inpatient stays, and improving customer satisfaction.

*****PLEASE FAX Completed Form to: 480-317-3358 or 1-800-323-9652*****

Please check any of the following criteria:

- ☐ Frequent ER visits or admissions (2 or more a month).
- ☐ Diagnosed with catastrophic/chronic illness or complications requiring major changes in lifestyle, living arrangement, caregiver roles.
- ☐ Behavioral/thought process changes that cause poor hygiene, poor nutrition, inappropriate decision process, poor or non-compliant with medications and/or prescribed medical treatment.
- ☐ High risk OB (please describe below).
- ☐ Non-adherent behavior (please describe below)
- ☐ Suspected financial or social problems.
- ☐ Suspected knowledge deficit about disease process or medication.

Why is patient being referred to Case Management?

_____

_____

List interventions initiated prior to Case Management referral (e.g. DME, Home Health, CHF, Outpatient Diabetes Program, Behavioral Health, ALTCS,ETC.):

_____

_____

DIAGNOSIS: _____

Continued on page 2

Case Management Referral Form Continued

Case Management findings & follow-up notes:

_____

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