Case management referral Form

eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

Section 1: Member information

Member contact name	Phone
Date of birth (mm/dd/yyyy)	Subscriber ID
Person making referral	Phone
Doctor name	Phone

Section 2: Referral information

Diagnosis and reason for case management referral
Projected outcome from case management

Ready to submit?

Mail, email or fax this form to EOCCO:

Mail: EOCCO Care Coordination team, P.O. Box 40384, Portland, OR 97240

Email: casemgmtrefer@modahealth.com | **Fax:** 503-243-5105

Questions? Contact a Care Coordination representative at 800-592-8283.

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