Empire BlueCross BlueShield

An Anthem Company

Disease Management Referral Form

All information contained on this form is strictly confidential and may become part of your patient's record.

Member's information	
Member's name:	Member's DOB:
Member's ID:	Gender: ☐Male ☐Female
Member's phone:	Alternate phone:
Referring physician's name:	Referral date:
Referring physician's phone:	Fax:

Health condition history	
□ Asthma	□ HIV/AIDS
□ Bipolar disorder	□ Hypertension (HTN)
□ Coronary artery disease (CAD)	□ Insulin dependency
□ Congestive heart failure (CHF)	□ Major depressive disorder (MDD)
□ Chronic obstructive pulmonary disease (COPD)	□ Schizophrenia
□ Diabetes	□ Substance use disorder (SUD)

Reason for referral

Additional comments:

Please fax form back to:
Disease Management Centralized Care Unit
1-888-762-3199 or 1-757-955-8891

www.empireblue.com/nymedicaiddoc

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