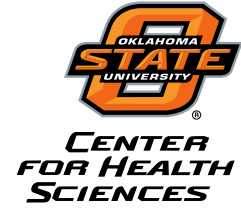


**Health Access Network  
Case Management Program**



**PROVIDER REFERRAL FORM**

<b>MEMBER NAME</b>	
DATE OF BIRTH	
MEDICAID ID NUMBER	
PROVIDER NAME	

DEAR PROVIDER:

- REASON FOR CASE MANAGEMENT REFERRAL:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SOONER CARE ENROLLMENT EFFECTIVE DATE : \_\_\_\_\_  
(if known)

- CLINIC STAFF PROVIDING REFERRAL: \_\_\_\_\_  
CONTACT #: \_\_\_\_\_

Please contact OSU HAN main office # for questions, concerns or to request specific education/interventions regarding Case Management Services at 918-561-1155. You may submit this referral form via fax at 918-561-1218 or e-mail to [osuhan@okstate.edu](mailto:osuhan@okstate.edu).

**Provider Handbook available upon request.**

Completed by OSU HAN Case Manager: \_\_\_\_\_ Date: \_\_\_\_\_