



**DELAWARE
PHYSICIANS CARE**
AN AETNA MEDICAID PLAN

**CASE MANAGEMENT PROGRAM
NOTIFICATION FORM**

Last Name: _____ First Name: _____

Address: _____ City: _____ State _____ Zip _____

County: _____ Phone Number: _____

Date of Birth: _____ Gender: _____ Member ID: _____

Guardian Name/Phone: _____

Emergency Contact Name/Phone: _____

Date Referred: _____ PCP Phone: _____

Referred by: _____ PCP Fax: _____

PCP Name: _____ PCP Email: _____

PCP Address: _____

Please check the appropriate case management service (s):

<input type="checkbox"/> Adults w/ Disabilities	<input type="checkbox"/> Dental	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Homeless
<input type="checkbox"/> Children w/ Special Needs	<input type="checkbox"/> EPSDT/Lead	<input type="checkbox"/> Perinatal
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> ESRD	<input type="checkbox"/> Substance Abuse

Diagnosis: _____

Case Management Needs: _____

Form should be faxed to Delaware Physicians Care Case Management Department at 1-866-947-8808