

Submission Options

Fax: Transmit to **844-978-2756**

Email: Send this form to **eccmreferrals@highmark.com**

Phone: Call our intake team at **844-GET-ECCM (844-438-3226)**

Please complete **every field** to help us get your patient the right support as quickly as possible.

About the Patient

Insurance

First Name:	Select the patient's insurance coverage: <input type="checkbox"/> Medicare (Parts A & B) <input type="checkbox"/> Highmark Medicare Advantage (MA) <input type="checkbox"/> WholeCare Medicaid <input type="checkbox"/> WholeCare D-SNP (Dual-Eligible Special Needs Plan) <input type="checkbox"/> Individual Affordable Care Act (ACA) <input type="checkbox"/> Highmark Enterprise Employees / Dependents Delaware Residents: <input type="checkbox"/> Highmark Health Options Medicaid <input type="checkbox"/> Highmark Health Options D-SNP (Dual-Eligible Special Needs Plan)
Last Name:	
Date of birth: (MM/DD/YYYY)	
Phone: ()	
Address Line 1:	
Address Line 2:	
Zip Code:	
Preferred Language:	
Are they currently inpatient? <input type="checkbox"/> No <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> LTAC	Anticipated Discharge Date:

What qualifies this patient for ECCM? (Select One)

- Serious Illness** List their life-impacting condition(s): _____
- Multiple Chronic Conditions + Frailty** List their long-term conditions: _____
- Multiple Chronic Conditions + Advanced Age (>80 years)** List their long-term conditions: _____

Who can we call if the patient doesn't answer?

Providing a second contact increases the likelihood that we can reach and engage the patient.

First Name:	Phone: ()
Last Name:	

Referring Practice / Provider

Practice / Facility / Agency Name:	
Referring Provider Name:	Phone: ()
Health System Name:	Fax: ()

Primary Care Provider Same as Above

PCP Name:	Phone: ()
Practice Name:	Fax: ()