

Iowa Medicaid Care Management Referral Form

Referral Source Information				
Name:		Address:		Telephone #:
City:	ZIP:	County:		County #:
Physician Name:		Physician Telephone #:		
Member Information				
Last Name:		First Name:		SID:
Address:			Telephone #: Alternate #:	
City:	Zip:	County:	County #:	
DOB:	Age:			
Reason for Referral:				
Number of hospitalizations in the last 2 months (if known):				
Diagnosis/Medications (if known):				

Referrals can be sent via email, mail, telephone or fax to the addresses or telephone numbers below.

Call or write the **Member Services Call Center** at:

PO Box 36510, Des Moines, Iowa 50315 – (800) 338-8366; (515) 256-4606 (local in the Des Moines area) Please visit our website at www.ime.state.ia.us or e-mail us at IMEMemberServices@dhs.state.ia.us