



# OneCare Kansas Referral Form

## Instructions

This form is designed to facilitate referrals of Medicaid members to the OneCare Kansas (OCK) program, which provides coordinated care management for individuals with certain qualifying chronic conditions. Referring organizations, such as hospitals, clinics, and other healthcare providers, should complete the first three sections if they believe their patient qualifies and could benefit from the program's services.

Once completed, the form should be sent to the assigned Managed Care Organization (MCO) using the contact information provided below. The form can be submitted to the MCO via fax, secure HIPPA compliant email, MCO portals, or standard mail. The MCO will then review and complete the remaining sections of the form and verify the member's eligibility. Eligible members will receive a mailed invitation to join the OCK program.

MCO Contact Information		
<b>Aetna Better Health of Kansas</b> Attention: Member Services 9401 Indian Creek Pkwy, Suite 1300 Overland Park, KS 66210 <a href="#">Email Aetna Better Health of Kansas</a> Phone: (855) 221-5656 Fax: (959) 282-8852	<b>Sunflower Health Plan</b> 8325 Lenexa Drive, Suite 200 Lenexa, KS 66214 <a href="#">Email Sunflower Health Plan</a> Phone: (877) 644-4623 Fax: (888) 453-4317	<b>United Health Care OneCare Kansas</b> 6860 W 115th St. Mail Route: KS015-M400 Overland Park, KS, 66211 <a href="#">Email United Health Care</a> Phone: (877) 542-9238 Fax: (855) 252-9324

## Section I: Referring Organization Information

Provide the following information for the organization initiating the referral.

**Organization Name:** \_\_\_\_\_

**Referring Contact Name:** \_\_\_\_\_

**Title of Referring Contact:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Email:** \_\_\_\_\_

## Section II: Member Information

Provide the following information regarding the individual being referred.

**MCO Assignment:**  Aetna  Sunflower  United

**Medicaid ID Number:** \_\_\_\_\_ **Date of Referral:** \_\_\_\_\_

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Section III: Eligibility Criteria

To be eligible for OneCare Kansas, an individual must be a Medicaid member and meet at least one of the following diagnostic criteria. Please select all applicable diagnoses for the referred individual and provide the corresponding diagnosis codes if available.

#### One Serious and Persistent Mental Illness

1. Select the following mental health conditions the individual has been diagnosed with:

- Schizophrenia  
Diagnosis Code: \_\_\_\_\_
- Bipolar Disorder  
Diagnosis Code: \_\_\_\_\_
- Major Depressive Disorder  
Diagnosis Code: \_\_\_\_\_

#### Asthma and Risk for Other Chronic Conditions

1. Does the individual have asthma and is at risk for another chronic condition?

- Yes, asthma is the primary condition  
Diagnosis Code: \_\_\_\_\_

2. If yes, select the following chronic conditions the individual is at risk for:

- Diabetes  
Diagnosis Code: \_\_\_\_\_
- Hypertension  
Diagnosis Code: \_\_\_\_\_
- Kidney Disease (not including Chronic Kidney Disease Stage 4 and ESRD)  
Diagnosis Code: \_\_\_\_\_
- Cardiovascular Disease  
Diagnosis Code: \_\_\_\_\_
- Chronic Obstructive Pulmonary Disease (COPD)  
Diagnosis Code: \_\_\_\_\_

