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		
Aetna Better Health of Kansas Attention: Member Services 9401 Indian Creek Pkwy, Suite 1300 Overland Park, KS 66210 Email Aetna Better Health of Kansas Phone: (855) 221-5656 Fax: (959) 282-8852	**Sunflower Health Plan** 8325 Lenexa Drive, Suite 200 Lenexa, KS 66214 Email Sunflower Health Plan Phone: (877) 644-4623 Fax: (888) 453-4317	**United Health Care OneCare Kansas** 6860 W 115th St. Mail Route: KS015-M400 Overland Park, KS, 66211 Email United Health Care 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: _____

☐ Mental Illness

Diagnosis Code: _____

☐ Metabolic Syndrome

Diagnosis Code: _____

☐ Morbid Obesity

Diagnosis Code: _____

☐ Substance Use Disorder

Diagnosis Code: _____

☐ Tobacco Use or exposure to second-hand smoke

Diagnosis Code: _____

Section IV: MCO Eligibility Determination

The following fields are to be completed by the MCO processing the referral request.

1. **Select the appropriate checkbox to indicate the member's eligibility status:**

   ☐ Medicaid Eligible (KMAP)

   ☐ Member meets OCK diagnosis criteria

   ☐ Member does not meet eligibility criteria *

2. * If the member does not meet eligibility criteria, specify the reasons for ineligibility:

Section V: MCO Follow-Up

The following fields are to be completed by the MCO processing the referral request.

MCO Representative Name: _____

Title of MCO Representative: _____ **Phone Number:** _____

Date Referral Received: _____ **Date Referral Reviewed:** _____

Referral Approved by MCO: ☐ Yes ☐ No **Date Invitation Letter Mailed:** _____