Medical Referral Form/MI Employee Group
Blue Cross Blue Shield Michigan to NDBH

NEW DIRECTIONS℠

Referral Date:	Member Name:
Member DOB:	Member ID#:
Member Phone#:	
Medical CM's Name:	Medical CM's Phone #:
Medical CM's Email:	
Is Member currently open in any programs with the BCBS CM?	
If "yes", which programs?	
Member's PCP's Name:	
PCP's Phone #:	PCP's Fax #:
Is Member under age 18?	
Does Member have a Legal Guardian? (Name and Phone # if applicable):	
Is Member aware of referral to NDBH?:	
Did Member agree to be contacted by NDBH?:	
Best time to reach Member:	
Requesting Service: ☐ Screening and Referral ☐ Integrated Case Management ☐ Other *explain Other	
Reason for Referral:	
Describe details of referral reason:	
List any Medical Conditions (describe if necessary) of Member:	
What is Primary Concern?:	

Please Email to: jcollins@ndbh.com & Michigan_CM@ndbh.com
Subject Line: Referral From Michigan FEP Medical Plan