Note: This must be a **SECURE** Email.

LA CSoC Referral Form

Date of Referral:	Healthy Louisiana Plan Name:		
Staff Referring:	Phone #:	Email:	
Youth Name:	Date of Birth:	Gender:	
Medicaid Number:	Anticipated Discharge Date:		
Legal Guardian(s) Name:	Relationship to Youth:		
Legal Guardian(s) Phone #1:	○ Cell	○ Home	○ Work
Legal Guardian(s) Phone #2:	○ Cell	○ Home	○ Work
Legal Guardian(s) Address:			
Parish:	○ Consent Form Attached		

Referral Source:	
Referral Contact:	Phone #:
*Reason for Referral:	Diagnosis (if known):
Current Behaviors:	
Medical Issues:	
Current Medications:	
Primary Care Physician Name:	Phone #:

Behavioral Health Provider #1 Name:	Phone #:	
Service Type:		
Behavioral Health Provider #2 Name:	Phone #:	
Service Type:		
Behavioral Health Provider #3 Name:	Phone #:	
Service Type:		
Behavioral Health Provider #4 Name:	Phone #:	
Service Type:		
Name of Facility (If Out Of Home Placement):		
Contact Name at Facility:	Contact #:	Other #:

IMPORTANT: Submit CSoC Referral Form to Email Address below:

Healthy Louisiana Plan	Email Address
Aetna Better Health	AetnaCSoCReferral@magellanhealth.com
Healthy Blue	HealthyBlueCSoCReferral@magellanhealth.com
AmeriHealth Caritas	AmerihealthCSoCReferral@magellanhealth.com
Louisiana Health Care Connections	LHCCSoCReferral@magellanhealth.com
United Health Care	UHCCSoCReferral@magellanhealth.com

For Magellan Use Only

○ *Returned to MCO*

Date:

Reason: