Medtronic
Care Management Services

UCR/UCare
Enrollment Form Rev B

Medtronic Disease Management Referral Form

Date: December 21, 2022

PROGRAM CRITERIA AND EXCLUSIONS

Medtronic Telemonitoring Program Criteria

☐ Heart Failure diagnosis
☐ 2 or more heart failure ED/hospitalizations in the last 15 months
☐ All Product Lines - for MSHO and MSC+ members with HF diagnosis regardless of ED/hospitalizations
☐ 18+ years old
☐ Not currently pregnant
☐ Member in agreement to participate in the disease management program

Exclusions:
☐ Diagnosis of ESRD (End Stage Renal Disease) ☐ On Hospice Care ☐ In Long Term Care Facility ☐ On dialysis

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:

Street Address:	Apt/Suite #:

City:	State:	Zip:	Telephone:

Date of Birth:	Preferred Language: ☐ English ☐ Spanish ☐ Other:	Gender: ☐ Male ☐ Female ☐ Other Preference

Email Address:

Member ID:	Priority Potential Referral: ☒ ***(for MCMS Internal Staff)***

EMERGENCY CONTACT INFORMATION

Last Name:	First Name:
Telephone:	Relationship:

PROVIDER CONTACT INFORMATION

Last Name:	First Name:	Type:
Telephone:	Fax:	Email:

ENROLLMENT INFORMATION

Disease monitoring program: ☒ Heart failure

Product Code/Managed Group: ☐ Connect ☐ Connect + Medicare ☐ Medicare Advantage MN ☐ MSC+ ☐ MSHO ☐ MNCare ☐ PMAP ☐ UCare IFP ☐ UCare M Health Fairview IFP ☐ Medicare – M Health Fairview North Memorial

COMPLETED BY:

Position/Job Title:	Email:
Name:	Telephone:

Fax to UCare at: 612-884-2497