PROVIDER *Update*

CalViva HEALTH

Health Net COMMUNITY SOLUTIONS

CONTRACTUAL | MAY 1, 2018 | UPDATE 18-282 | 3 PAGES

Revised Medi-Cal Care Management Referral Form

Health Net Community Solutions, Inc. (Health Net), on behalf of CalViva Health, has revised the *Care Management Referral Form* for Medi-Cal members. Providers must use this form when referring a Medi-Cal member for care or disease management. The *Care Management Referral Form* is attached for reference and available on the provider website at provider.healthnet.com in the Provider Library under *Forms*.

Providers can refer a Medi-Cal member for care or disease management by completing and submitting the *Care Management Referral Form* via fax to 1-866-581-0540 or email to CASHP.ACM.CMA@healthnet.com.

For questions about how to complete this form, contact the Health Plan's Care Management Department at 1-866-801-6294.

REFERRAL CRITERIA

Providers can refer members to the care management programs when they have a significant, life-limiting diagnosis with multiple comorbid conditions and critical barriers to their care. Many of these members have diagnoses that are no longer responding to typical treatment regimens, or are unable to participate in aggressive treatment without additional support. The care management programs manage members who are experiencing acute and severe events, such as:

- Complex chronic conditions, such as diabetes, asthma, chronic obstructive pulmonary disease (COPD), and vascular or active cancers.
- Multiple comorbidities.
- A health event that has the potential for significant consumption of resources (medical or financial).
- Complications relating to frail health status.
- Those experiencing frequent or prolonged hospitalizations or emergency visits.
- Multiple psychosocial factors, such as need for support system, transportation, financial resources, decision support, habilitation, or residential needs.
- Functional impairment, such as dependency for activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
- Individuals who are eligible by law, such as those with mental or developmental disabilities.

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact CalViva Health at 1-888-893-1569.

THIS UPDATE APPLIES TO MEDI-CAL PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

PROVIDER SERVICES

1-888-893-1569
www.healthnet.com

Care Management Referral Form

DIRECTIONS: To refer a CalViva Health member to any of our care management programs or services (case management or disease management), please fax this completed form to 1-866-581-0540 or email the completed form to CASHP.ACM.CMA@healthnet.com. If you have questions about how to complete this form, please call the Care Management Department at **1-866-801-6294.**

Part 1: Referring Provider Information

Provider first and last name:		Referral date:
Office contact person:	Provider telephone number:	Provider fax number:

For which care management program/service are you making a referral? (check all that apply)

☐ Case Management ☐ Disease Management

Part 2: Member Information

Member first and last name:	Medi-Cal ID#:	Date of birth:
Member address:	City:	ZIP code:
Member telephone number:		

Member Diagnosis / Health Condition:

(Check all that apply)

- ☐ Asthma
- ☐ Back pain
- ☐ Behavioral health
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Autism
  - ☐ Other (specify) _____
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Hemophilia
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Obesity-weight management
- ☐ High-risk pregnancy
- ☐ Prematurity and/or developmental delays
- ☐ Sickle cell disease
- ☐ Smoking cessation
- ☐ Hepatitis
- ☐ Transplant
- ☐ Traumatic brain injury
- ☐ Other:_____

Care Management Referral Form

Please check if any of the following referral reasons apply to the member:

- ☐ Member needs prenatal care education and support services.
- ☐ Member needs disease management/health coaching for his/her illness or condition.
- ☐ Member needs referral for: ☐ housing/shelter, ☐ food, ☐other (specify) _____.
- ☐ Member needs education on prescriptions and compliance.
- ☐ Concerned about high emergency room utilization or frequent hospitalizations.
- ☐ Member needs transportation to medical appointments.
- ☐ Member needs assistance with medical equipment.
- ☐ Member needs assistance with behavioral health services.
- ☐ Other (specify) _____

Part 3: Signature

Sign here➢ _____ _____

Signature of physician/provider Date