

Care Management Referral Form



DIRECTIONS: Select the member's plan below and email or fax the completed referral.

- **CA Commercial (Ambetter HMO/PPO, Employer Group plans (HMO, PPO, POS)) and Medicare Employer Groups** – Email completed form to Case.Management.Referrals@healthnet.com or fax completed form to **800-745-6955**.
- **CA Medicare** (including Medicare Advantage) for shared risk non-delegated plans. – Email completed form to Medicare_CM@healthnet.com or fax completed form to **866-290-5957** for physical health care management. Note: For behavioral health care management, refer special needs plan members to MHN via email to mhn.snp@healthnet.com.
- **CA Medi-Cal** – Email completed form to CASHP.ACM.CMA@healthnet.com or fax completed form to **866-581-0540**.

URGENT Request

UC Blue & Gold Plan Member

Part 1: Referring Source

First and last name:		Referral date:
Office contact person:	Phone number:	Fax number:

Part 2: Member Information

Member first and last name:	Member ID#:	Date of birth:
Member address:	City:	ZIP Code:

Member phone number:

Member Diagnosis/Health Condition (check all that apply):

<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Back pain	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine/tension headache
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Autism	<input type="checkbox"/> Frozen shoulder	<input type="checkbox"/> Obesity-weight management
<input type="checkbox"/> Depression	<input type="checkbox"/> Golf/tennis elbow	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Prematurity and/or developmental delay
<input type="checkbox"/> Bursitis/tendonitis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> CAD	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sickle cell
<input type="checkbox"/> Cancer	<input type="checkbox"/> High risk pregnancy	<input type="checkbox"/> Transplant
<input type="checkbox"/> Carpal tunnel syndrome	Estimated date of delivery __/__/__	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Other: _____

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

- Concerned about high emergency room utilization or frequent hospitalizations.
- Exhaustion of benefits
- Member needs assistance with behavioral health needs.
- Member needs assistance with medical equipment.
- Member needs assistance with resources for: housing/shelter, food, other (specify) _____.
- Member needs education on prescriptions and compliance.
- Member needs education/support with managing his/her chronic condition(s).
- Member needs prenatal care education and support services.
- Member needs transportation to medical appointments.
- Safety concerns.
- Other (specify) _____

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Please use this page to provide additional information (as needed).