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):

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

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