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.
- **CA Medi-Cal** – Email completed form to **CASHP.ACM.CMA@healthnet.com** or fax completed form to **866-581-0540**.
- **Referral to palliative care** – Email completed form to CareConnections@Healthnet.com.

☐ *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:

- ☐ Member needs assistance with palliative care: _____
- ☐ 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).