## **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):				
<ul> <li>Asthma</li> <li>Back pain</li> <li>Behavioral health</li> <li>Anxiety</li> <li>Autism</li> <li>Depression</li> <li>Other (specify)</li> <li>Bursitis/tendonitis</li> <li>CAD</li> <li>Cancer</li> <li>Carpal tunnel syndrome</li> <li>Clinical Trials</li> </ul>	<ul> <li>COPD</li> <li>Cystic fibrosis</li> <li>Diabetes</li> <li>Fibromyalgia</li> <li>Frozen shoulder</li> <li>Golf/tennis elbow</li> <li>Heart failure</li> <li>Hemophilia</li> <li>Hepatitis</li> <li>High risk pregnancy Estimated date of delivery</li> <li>HIV/AIDS</li> </ul>		<ul> <li>Hypertension</li> <li>Kidney disease</li> <li>Migraine/tension headache</li> <li>Musculoskeletal</li> <li>Obesity-weight management</li> <li>Osteoarthritis</li> <li>Prematurity and/or developmental delay</li> <li>Rheumatoid arthritis</li> <li>Sickle cell</li> <li>Transplant</li> <li>Traumatic brain injury</li> <li>Other:</li> </ul>	
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 assistance with managing his/her chronic condition(s).         Member needs transportation to medical appointments.         Safety concerns.         Other (specify)				

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