

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

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