Care Management Referral Form

DIRECTIONS: To refer a California Health & Wellness Member to any of our care management programs or services (i.e. case management, disease management or MemberConnections®), please fax this completed form to **1-855-556-7909** or mail it to: California Health & Wellness, 1740 Creekside Oaks Drive, Suite 200, Sacramento CA 95833. If you have questions about how to complete this form, please call California Health & Wellness at **1-877-658-0305** and ask for Case Management.

Part 1: Referring Provider Information

Provider First and Last Name:		Referral Date:
Office Contact Person:	Provider Phone Number:	Provider Fax Number:

Which care management program/service are you making a referral for? (check all that apply)

☐ Case Management ☐ Disease Management ☐ MemberConnections®

Part 2: Member Information

Member First and Last Name:	Medi-Cal ID#:	Date of Birth:
Member Address:	City:	Zip Code:
Member Phone Number:		

Member Diagnosis / Health Condition:

(Check all that apply)

☐ Asthma	☐ HIV/AIDS
☐ Back Pain	☐ Hypertension
☐ Behavioral Health	☐ Kidney Disease
☐ Congestive Heart Failure	☐ Obesity-Weight Management
☐ COPD	☐ Pregnancy-Submit Notification of Pregnancy Form
☐ Cystic Fibrosis	☐ Prematurity and/or Developmental Delays
☐ Diabetes	☐ Sickle Cell Disease
☐ Hemophilia	☐ Smoking Cessation
☐ Cancer	☐ Other:_____

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

☐ Member missed 2 consecutive appointments or multiple appointments within 3 months
☐ Member needs prenatal care education and support services (i.e. Start Smart for Your Baby Program)
☐ Member needs disease management/health coaching for his/her illness or condition
☐ Member needs referral for: ☐ transportation ☐ housing/shelter ☐ food ☐other (specify) _____
☐ Concerned about medication compliance
☐ Concerned about high emergency room utilization

☐ Other (specify) _____

Part 3: Signature

Sign Here ➢ _____ _____

Signature of Physician/Provider Date