Care Management Referral Form

DIRECTIONS: To refer a California Health & Wellness Member to any of our care management programs or services (case management or disease management), 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

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
	☐ Back Pain
	☐ Behavioral Health
	  ☐ Depression
	  ☐ Anxiety
	  ☐ Autism
	  ☐ Other (Specify) _____
	☐ Congestive Heart Failure
	☐ COPD
	☐ Cystic Fibrosis
	☐ Diabetes
	☐ Hemophilia
	☐ Cancer
	☐ HIV/AIDS
	☐ Hypertension
		☐ Kidney Disease
		☐ Obesity-Weight Management
		☐ Pregnancy-Submit Notification of Pregnancy Form
		☐ Prematurity and/or Developmental Delays
		☐ Sickle Cell Disease
		☐ Smoking Cessation
		☐ Hepatitis
		☐ Transplant
		☐ Traumatic Brain Injury
		☐ Other:_____

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

- ☐ 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: ☐ housing/shelter, ☐ food, ☐other (specify) _____
- ☐ Member needs education on prescriptions and compliance
- ☐ Concerned about high emergency room utilization or frequent hospitalizations
- ☐ Member needs transportation to medical appointments
- ☐ Member needs assistance with medical equipment
- ☐ Member needs assistance with behavioral health services
- ☐ Other (specify) _____

Part 3: Signature

Sign Here➢ _____ _____

Signature of Physician/Provider Date