Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Community Health Worker Referral Form

To refer your patient to a community health worker, please return this form by fax to **1-844-429-9626** or email to CHWReferral@anthem.com. This form is for Medi-Cal Managed Care (Medi-Cal) members only. Referral processing will take 2 to 3 business days.

Section 1: Referring person information		
Referral date:	Name of referring person and title:	Clinic/agency:
Email address:	Phone number:	Fax number:

Section 2: Member information			
Name: (First name) (Last name)			Parent/caregiver/ guardian name (if minor):
Member ID:	Date of birth:	Primary phone:	
Primary language:		Alternate phone:	

Alternate contact person name:
Phone number:
Relationship:

Does member have primary Medi-Cal coverage? ☐ Yes ☐ No (explain):

Is member/caregiver/guardian aware of referral to community health worker? ☐ Yes ☐ No

Is member receiving support from another organization? ☐ Yes ☐ No

- If yes, provide worker name/contact information/organization:

Section 3: Reason for referral: Select all that apply and explain.

☐ Counseling/social support services:
☐ Need help with dental health/dentist:
☐ Need help with access to vision plan:
☐ Need support with healthcare:
☐ Need support with scheduling medical appointments:
☐ Need assistance with durable medical equipment issue:
☐ Need support with social determinants of health (housing assistance, food insecurity, transportation, community-based resources, phone service, employment, education, caregiver support, financial assistance):

☐ Other assistance:

https://providers.anthem.com/ca

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