Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Medical Respite Referral Form

Please fax this completed form to the Anthem Blue Cross (Anthem) Special Programs department at 844-429-9626 or submit via secure email to CASpecialPrograms@anthem.com.

The purpose of the Anthem Medical Respite Program is to improve health outcomes for recuperating Anthem members who are experiencing homelessness by providing recuperative care and external case management (ECM) services following a discharge from a hospital, skilled nursing facility (SNF), or diversion from emergency departments. The member must meet eligibility criteria as outlined below. Space is limited.

Member information		
Member name:		
Member ID:	Member DOB:	
Member gender:	Primary language:	Ethnicity:
Member/caregiver phone number (if available):		
Is this member a veteran? Yes ☐ No ☐		
Current member status		
Admission date: ☐ Inpatient ☐ ED ☐ Outpatient	Anticipated discharge date:	
Admission reason:		
Referring parties		
External referral by (select one): ☐ Hospital ☐ SNF ☐ PCP ☐ Community organization IPA/PMG		
Name of organization:	Department/floor submitting referral:	
Phone:	Fax:	
Email:		
Assisted devices and home health needs		
Does the member have any impairments?	☐ Blind ☐ Partially blind ☐ Deaf ☐ Nonverbal ☐ TBI ☐ Cognitive	
Does the member use assistive devices?	☐ Cane ☐ Crutches ☐ Wheelchair ☐ Walker ☐ Other	

ACAPEC-2903-21 June 2021

Does member require home health? ☐ Yes ☐ No	If yes, what type of home health therapy? ☐PT ☐OT ☐ST
	Home health provider name:
	Home health provider contact information:
	Home health authorization number (if applicable):
Does the member require durable medical equipment (DME)? ☐ Yes ☐No	If yes, what is the DME provider name?
	DME provider contact information:
	DME authorization number (if applicable):

Mental health information	
Does the member have a mental illness? ☐ Yes ☐ No ☐ Unknown	
Does the member have a mental health provider? ☐Yes ☐ No ☐ Unknown	
If yes, provide name and phone number of mental health provider (if applicable):	
Name:	Phone number:
Does member have a history of substance use disorder (SUD)? ☐ Yes ☐ No ☐ Unknown	
Legal history: ☐ Parole ☐ Probation ☐ Unknown	

Additional comments/concerns