

## Care Management Referral Form

**For physical health case management (CM):**

**Fax: 866-333-4827**

**Email: CAMedicaidPHCM@anthem.com**

**For behavioral health CM:**

**Fax: 855-473-7902**

**Email: bhcmreferrals@anthem.com**

*This form is for Medi-Cal Managed Care (Medi-Cal) members only. Refer to **only one program** (choose either physical health or behavioral health CM based on primary referral reason).*

*(Referral processing time: within three business days of submission)*

Referrer information		
Date referral submitted:	Name of person submitting referral:	Organization (if applicable):
Phone number:	Email address:	Fax number:

Member information		
Does member have primary Medi-Cal coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (explain):	First and last name:	Parent/guardian name (if minor):
Member ID:	Date of birth:	Primary phone:
Primary language:	Alternate phone:	
Has member/caregiver been informed of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is member receiving CM from another organization? <input type="checkbox"/> Yes <input type="checkbox"/> No		
➤ If yes, provide case manager name/contact information:		

Primary diagnoses/conditions:		
<input type="checkbox"/> Asthma	<input type="checkbox"/> HTN	<input type="checkbox"/> Substance use
<input type="checkbox"/> CAD	<input type="checkbox"/> High-risk pregnancy	<input type="checkbox"/> Mild-mod behavioral health diagnosis (list):
<input type="checkbox"/> CHF	<input type="checkbox"/> Sickle cell	_____
<input type="checkbox"/> COPD	<input type="checkbox"/> Child/youth with special healthcare needs	_____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Transplant	<input type="checkbox"/> Other (list): _____
<input type="checkbox"/> Diabetes		_____
<input type="checkbox"/> ESRD		_____

Admission history (Select all that apply.):	
<input type="checkbox"/> ≥ 2 hospitalizations in 12 months	<input type="checkbox"/> Readmitted to hospital within past 30 days
<input type="checkbox"/> ≥ 3 ER visits in last 12 months	<input type="checkbox"/> Discharged from hospital within last 7 days
<input type="checkbox"/> ER visit within last 7 days	

Why are you referring to CM? (Select all that apply and explain.)
<input type="checkbox"/> Difficulty accessing medical specialty care:
<input type="checkbox"/> Difficulty accessing behavioral health specialty care:
<input type="checkbox"/> Difficulty managing medical conditions:
<input type="checkbox"/> Difficulty getting medications (include name(s) of medication):
<input type="checkbox"/> Need support with social drivers of health:
<input type="checkbox"/> Need support with transition between care settings:
<input type="checkbox"/> Other:

<https://providers.anthem.com/ca>

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