

Care Management Referral Form

For physical health CM:

Fax: 1-866-333-4827

Email: CAMedicaidPHCM@anthem.com

For behavioral health CM:

Fax: 1-855-473-7902

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 3 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? Yes No

Is member receiving care management from another organization? Yes 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 dx (list):
<input type="checkbox"/> CHF	<input type="checkbox"/> Sickle Cell	_____
<input type="checkbox"/> COPD	<input type="checkbox"/> Child/youth with special health care 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 Determinants of Health (SDOH):
<input type="checkbox"/> Need support with transition between care settings:
<input type="checkbox"/> Other:

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

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