Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Health Education and Cultural and Linguistic Referral Form

Provider information — Please print clearly			
Referred by		Date	
Phone number		Fax number	
Address			
☐ Please check box if member follow up documentation is desired and indicate fax number clearly above.			
Member information			
Member name		Date of birth	
Medi-Cal Managed Care identification number		Language spoken	
Address		Cell phone	
City, State ZIP code			
Special accommodations	☐Vision ☐Hearing ☐Physical ☐Other: _____		
Cultural and linguistic request			
Type of service requested:			

Requested service: health education topic (check all that apply)	**Under 18**	**Ages 18+**
Asthma		
Breastfeeding		
Diabetes		
Exercise/Physical activity		
Family planning/Unintended pregnancy prevention		
HIV/STD prevention		
Hypertension		
Injury prevention		
Nutrition		
Obesity		
Parenting		
Perinatal/Pregnancy		
Substance abuse (alcohol and drugs)		
Tobacco prevention and cessation		
Other (please specify):		

Specifications for: exercise/physical activity, obesity/weight management, and nutrition			
Cleared to exercise without restrictions? ☐ Yes ☐ No, specify_____			
Provider name (print)		Date	
Provider signature			
Provider special instrutions/comments – Attach additional pages if necessary.			

Email this form to HealthEd_CA_Medicaid@anthem.com.

Do not send medical records.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

https://providers.anthem.com/ca

ACAPEC-3105-21 October 2021