blue california
Promise Health Plan

Population Health Management Referral From

Member Information		
Date of referral:	Member ID:	
Member first name:	Member last name:	
Date of birth:	Gender: ☐ Male ☐ Female	
Address:	City:	ZIP code:
Member phone number:	Preferred spoken language:	

Type of Case Management services needed (check <u>one</u>)	
☐ Disease management	
☐ Asthma	☐ Congestive Heart Failure (CHF)
☐ Cardiovascular Disease	☐ Depression
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Diabetes
☐ Complex Case Management	
☐ Maternity Case Management	
☐ Children with Special Health Care Needs (CSHCN)	
☐ California Children's Services (CCS)	
☐ Early Start-Early Intervention, Developmental Disability Services (EIES-DDS)	
☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	

Reason for case management services (check <u>all</u> that apply)	
☐ Difficulty controlling symptoms	☐ Medication or treatment non-compliance
☐ Assistance with self-management	☐ Poly-pharmacy
☐ Assistance with care coordination	☐ Poorly controlled chronic conditions
☐ Multiple hospital admissions and ER visits	☐ Caregiver or social issues
Diagnosis:	
Additional information:	

Referral source information	
Physician name:	☐ Primary care provider ☐ Specialist
Phone number:	IPA:

Fax form with pertinent medical records and information to:
Los Angeles County: (323) 889-6575
San Diego County: (619) 219-3302