blue of california

Care Management Referral Form

email: EDHCCMReferral@blueshieldca.com

Fax: 916-350-6095

Referral Source

Source of referral: ☐ Member/Self ☐ Provider ☐ Blue Shield

Contact Name **(required)**	
Provider's Name (if applicable)	
Phone **(required)**	( )
Email (optional)	

Member

First Name **(required)**			
Last Name **(required)**			
Preferred Name (optional)			
Member ID **(required)**		Phone **(required)**	( )
Date Of Birth **(required)**	/ /		
Gender **(required)**	☐ Female ☐ Male ☐ Non-Binary Another Gender		
Address (optional)			
City (optional)		State	Zip

Program

☐ **Care management**

☐ **Prenatal**

Comments

Thank you for your referral