blue of california

Care Management Referral Form

email: **CMReferral@blueshieldca.com**

fax: **(877) 280-0179**

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