

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? ☐ Yes ☐ 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:

☐ Asthma	☐ HTN	☐ Substance use
☐ CAD	☐ High-risk pregnancy	☐ Mild-mod behavioral health dx (list):
☐ CHF	☐ Sickle Cell	_____
☐ COPD	☐ Child/youth with special health care needs	_____
☐ Cystic Fibrosis	☐ Transplant:	☐ Other (list): _____
☐ Diabetes		_____
☐ ESRD		_____

Admission history (Select all that apply.):

☐ ≥ 2 hospitalizations in 12 months	☐ Readmitted to hospital within past 30 days
☐ ≥ 3 ER visits in last 12 months	☐ Discharged from hospital within last 7 days
☐ ER visit within last 7 days	

Why are you referring to CM? Select all that apply and explain.

☐ Difficulty accessing medical specialty care:
☐ Difficulty accessing behavioral health specialty care:
☐ Difficulty managing medical conditions:
☐ Difficulty getting medications (include name(s) of medication):
☐ Need support with Social Determinants of Health (SDOH):
☐ Need support with transition between care settings:
☐ Other:

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

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