blue california
Promise Health Plan

Community Supports (CS) Request Form

To Submit Referrals or Questions, Send a Secured Email:
Los Angeles County: LACommunitySupports@blueshieldca.com
San Diego County: SDCommunitySupports@blueshieldca.com

Request Type:
☐ URGENT ☐ ROUTINE

I. MEMBER INFORMATION

PRIMARY LANGUAGE SPOKEN: **Gender:**
Other Language: **Member Consented to Referral:**

Last Name: First Name: MI: DOB:

BSC ID: CIN #: BSC Plan/Coverage:

Address: Apt/Unit:

City: Zip Code: Phone #(s):

II. REQUESTOR INFORMATION

Date of Request: **Requestor Name:**

Requestor Phone #: **Requestor Fax #:** **BSC Promise ECM Provider?:**

Requestor Agency/Provider Group: **Requester Email:**

III. COMMUNITY SUPPORT SERVICE(S) REQUESTED

***For Home Modification and Housing Deposits:** Request is incomplete without providing itemized list of requested services. Request must include specific amount(s)

CS Type Requested	Requested Start Date	End Date (if applicable)	Requested Duration (if applicable)

Diagnosis(es) Code(s)

Diagnosis Description(s)

Reason for Referral

IV. FOR BSCPHP USE ONLY: Blue Shield Promise CS Request Decision:

◯ **APPROVED** **Auth Start Date:** **Auth End Date:** **Total Amount/Units Approved:** **Auth #:**

◯ **DENIED** **Denial Reason:** **Narrative:**

◯ **REQUEST RESCINDED** **Rescind Reason:** **Other:**

Reviewer's Name: **Signature:** **Date Reviewed/Decisioned:**

BSCPHP USE ONLY: Member Eligibility verified as of:

THIS REFERRAL DOES NOT GUARANTEE ELIGIBILITY. CHECK ELIGIBILITY PRIOR TO RENDERING SERVICE.
Payment will NOT be made for unauthorized services.

Revised: 9/9/2022