blue california
Promise Health Plan

Population Health Management Referral Form

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 one)	
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 Heath Care Needs (CSHCN)	

REASON FOR CASE MANAGEMENT SERVICES (check all 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 or 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

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