



P R O M I S E

Community Supports (CS) Request Form

Blue Shield of California Promise Health Plan

To submit referrals or questions, send a secure email to:
CommunitySupports@blueshieldca.com

REQUEST TYPE:	
URGENT	ROUTINE
Member consented to referral: Yes No	

I. MEMBER INFORMATION		Primary language spoken:	
Last name:		Other language(s):	
First name:		MI:	DOB:
Member ID:		CIN#:	Plan type:
Address:		Apt/Unit:	Gender:
City:		ZIP code:	Phone:
II. REQUESTOR INFORMATION			
Date of request:		Requestor name:	
Requestor phone:		Requestor fax #:	
Requestor agency/provider group:		Requestor email:	
		Blue Shield Promise ECM provider? Yes No	
III. COMMUNITY SUPPORT SERVICE(S) REQUESTED			
*For Home Modification and Housing Deposits: Requests are incomplete without an itemized list of desired services and must include specific amount(s).			
*For Transitional Rent: Requests are incomplete without a Housing Support Plan that meets all requirements, including a solution (or prevention strategy) for members at risk of homelessness.			
CS type requested	Requested start date	End date (if applicable)	Requested duration
Diagnosis code(s):			
Diagnosis description(s):			
Reason for referral:			
IV. FOR BLUE SHIELD PROMISE USE ONLY – CS Request Decision			
APPROVED	Auth start date:	Auth end date:	Total units approved: Auth#
DENIED	Reason for denial:	Narrative:	
REQUEST RESCINDED	Rescind reason:	Other:	
Reviewer's name:	Signature:	Date reviewed/decided:	
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.

blueshieldca.com/promise