blue california | Promise Health Plan

DISEASE MANAGEMENT REFERRAL FORM

Member Demographics:		
Member Name:		Member ID:
Mailing Address: Street/City/State/Zip		
Gender: F ☐ M ☐	Home Phone: ( )	

Referring Physician's Information:		
Referring Physician:		PCP ☐ Specialist ☐
IPA:		Phone: ( )

Disease Management Program:	
Medi-Cal Programs	Medicare Programs
☐ Asthma	☐ CHF
☐ CHF	☐ COPD

Other Relevant Diagnosis:

Reason(s) for Referral:	
☐ Difficulty Controlling Symptoms	☐ Non-Compliance with Medications
☐ Education for Self-Management Recent	☐ Non-Compliance with Treatment
☐ Hospitalizations	☐ Plan Poly-pharmacy
☐ Frequent ER Visits	☐ Co-Morbidities
☐ Hospital Readmissions same/similar Dx.	☐ Care Giver/Environmental Issues

Comments:

***Physician Signature:*____________________________________** ***Date:*_____________**

Please Fax to:
Mail Attention to:
Blue Shield of California Promise Health Plan
Disease Management
Fax #: (323) 889-6517
601 Potrero Grande Dr., Monterey Park, CA 91755

Enrollment criteria must be met to qualify for Blue Shield of California Promise Health Plan programs.

Important Warning: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is Strictly Prohibited. If you have received this message by error, please notify the sender immediately to arrange for return or destruction. Unauthorized re-disclosure for failure to maintain confidentiality could subject you to penalties described in federal and state law.

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.