



Health Net
Healthcare Services Department
CASE MANAGEMENT REFERRAL FORM
 URGENT STANDARD

This form is for outpatient CASHP case management ONLY. Claim issues, PCP changes, locating specialists or transportation requests are processed via Member Services.

For Medi-Cal member with a provider access issue, please redirect to PCP and PPG. All inquiries regarding members who are currently in a SNF, hospital, rehab, etc, are to be referred to the Concurrent Review department (CCR). All questions regarding member authorizations, DME etc., contact Prior Auth department (PA).

E-Mail completed form to: CASHP. ACM. CMA@healthnet.com
or Fax to: 866-581-0540

Date:	Associate Name/Department:	Contact Phone #:
Member Name:		Product/Tier (If Applicable):
Subscriber #:	DOB:	Member Phone #:
Primary Diagnosis:		
Contact Person/Relationship to member:		Phone #:
Attending MD/Specialist Name:		Phone #:

Must check one of the boxes below as well as fill out the comment section to include why member is requesting Case Management

Specialty Programs: *(please select all that apply)*

- Complex Case Management
 Diabetes
 Transition/Continuity of Care with completed information
 Congestive Heart Failure
 End Stage Renal Disease (ESRD)/dialysis
 Transplant (Potential/Actual)
 COPD Asthma
 High Risk OB (HROB)
 CBAS/LTSS/IHSS services

Ambulatory CM Referral Reason:

<input type="checkbox"/> Treatment/Medications needed at this time <input type="checkbox"/> Needs following hospital discharge or ER visits <input type="checkbox"/> Needs coordination of finances to meet health needs <input type="checkbox"/> Premature/delayed discharge from appropriate level of care <input type="checkbox"/> Current disease/illness process <input type="checkbox"/> Temporary or permanent onset of new disability	<input type="checkbox"/> Inappropriate utilization of services <input type="checkbox"/> Patient safety concerns <input type="checkbox"/> High cost ongoing injury illness <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> General Case Management request
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***Notes/Comments:** *(Referral reason must be clearly indicated below)*
