Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Care Management Referral Form

For physical health CM:
Fax: 1-866-333-4827
Email: CAMedicaidPHCM@anthem.com

For behavioral health CM:
Fax: 1-855-473-7902
Email: bhcmreferrals@anthem.com

*This form is for Medi-Cal Managed Care (Medi-Cal) members only. Refer to **only one program** (choose either physical health or behavioral health CM based on primary referral reason).*

(Referral processing time: Within 3 business days of submission)

Referrer information		
Date referral submitted	Name of person submitting referral	Organization (if applicable)
Phone number	Email address	Fax number

Member information			
Does member have primary Medi-Cal coverage? ☐ Yes ☐ No (explain):	First and last name		Parent/ guardian name (if minor)
Member ID	Date of birth	Primary phone #	
Primary language		Alternate phone #	

Has member/caregiver been informed of referral? ☐ Yes ☐ No

Is member receiving care management from another organization? ☐ Yes ☐ No

- If yes, provide case manager name/contact information:

Primary diagnoses/conditions:

☐ Asthma
☐ CAD
☐ CHF
☐ COPD
☐ Cystic Fibrosis
☐ Diabetes
☐ ESRD
☐ HTN
☐ High-risk pregnancy
☐ Sickle Cell
☐ Child/youth with special health care needs
☐ Transplant:
☐ Substance use
☐ Mild-mod behavioral health dx (list):
_____
_____
☐ Other (list): _____
_____

Admission history (Select all that apply.):

☐ ≥ 2 hospitalizations in 12 months
☐ ≥ 3 ER visits in last 12 months
☐ ER visit within last 7 days
☐ Readmitted to hospital within past 30 days
☐ Discharged from hospital within last 7 days

Why are you referring to CM? Select all that apply and explain.

☐ Difficulty accessing medical specialty care:
☐ Difficulty accessing behavioral health specialty care:
☐ Difficulty managing medical conditions:
☐ Difficulty getting medications (include name(s) of medication):
☐ Need support with Social Determinants of Health (SDOH):
☐ Need support with transition between care settings:
☐ Other:

https://providers.anthem.com/ca

ACAPEC-2687-21 February 2021