



Case Management Request Form

CHOC Health Alliance strives to provide your patients with the best quality of care. The Case Managers at CHOC Health Alliance are highly qualified and will help to ensure members receive all the appropriate health and social services needed.

Please fax back along with pertinent clinical notes to (855) 867-0868

Member Name: _____ **Date of Submission:** _____

Birth Date: _____ **CIN#** _____ **Phone#:** _____

Requesting Provider: _____ **Phone#:** _____ **Fax#:** _____

Member's Diagnosis:

1. _____
2. _____
3. _____

Has the Caregiver/Patient been informed that CM referral has been submitted: Yes _____ No _____

Please select the reason for referral to Case Management:

- | | |
|---|--|
| <input type="checkbox"/> Chronic Illness/Complicated/Multiple Diagnoses | <input type="checkbox"/> Overwhelmed Family/Caregiver(s) |
| <input type="checkbox"/> High Utilization (High Inpatient/ED Use) | <input type="checkbox"/> Non Compliance |
| <input type="checkbox"/> Behavior/Mental Health Issues/Social issues | <input type="checkbox"/> Multiple Specialty/DME needs |
| <input type="checkbox"/> NICU Graduate | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Other _____ | |

Comments: _____

