CHOC HEALTH ALLIANCE

## 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 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:**

- ☐ Chronic Illness/Complicated/Multiple Diagnosis
- ☐ Overwhelmed Family/Caregiver(s)
- ☐ High Utilization (High Inpatient/ED Use)
- ☐ Non Compliance
- ☐ Behavior/Mental Health Issues/social issues
- ☐ Multiple Specialty/DME needs
- ☐ NICU Graduate
- ☐ Pregnancy
- ☐ Other_____

**Comments:**_____

_____

_____

_____