CHOC Health Alliance Care Coordination/Case Management Request Form

Please fax to CHA Member Services: 855-867-0868

I. General Information

Submission Date:

Member's Name:

CIN # (If available):

Date of Birth:

MRN # (Cerner):

Phone #:

Parent/Caregiver's Name:

Preferred Language:

Relationship to Member:

II. Requesting Provider

Requesting Provider:

Provider's Phone #:

Provider's Fax #:

Request Type: ☐ URGENT ☐ NON URGENT

Is the Member/Caregiver aware of the CM referral: ☐ YES ☐ NO

III. Member's Diagnosis:

1) _____

2) _____

3) _____

4) _____

5) _____

IV. Reasons for Referral:

☐ Chronic Illness/Complicated/Multiple Diagnosis ☐ Overwhelmed Family ☐ Transition of Care (Age Out)

☐ High ED/Frequent Admissions ☐ Non-Compliance ☐ Multiple Specialty/DME Needs

☐ Mental Health ☐ Behavioral Health ☐ Other: _____

V. Family or Provider's Concerns:

_____

_____

_____

_____

VI. CHOC Health Alliance Only

Based on needs, member will be receiving the following:

☐ Interdisciplinary Care Team Meeting ☐ Case Management (Requested By Provider)

☐ Patient Care Coordinator Services ☐ Other: _____

We will be contacting the member/member's parent. For further questions or concerns, please contact Liz Grant: 714-509-7050.