

Scripps Health Plan Services Care Management Referral Form

Date of Referral:

Member name:

Date of Birth:

Member address:

Member phone number:

Type of Care Management services needed: (check one)

<input type="checkbox"/>	Disease Management
<input type="checkbox"/>	Complex Case Management

Reason for Care Management Services: (check all that apply)

<input type="checkbox"/>	Difficulty controlling symptoms	<input type="checkbox"/>	Medication or treatment non-compliance
<input type="checkbox"/>	Assistance with self-management	<input type="checkbox"/>	Poly-pharmacy
<input type="checkbox"/>	Assistance with care coordination	<input type="checkbox"/>	Poorly controlled chronic conditions
<input type="checkbox"/>	Multiple hospital admissions or ER visits	<input type="checkbox"/>	Caregiver or social issues

Primary diagnosis:

Additional information:

Form with supporting documentation may be emailed/faxed to:

E-Mail: shcmreferrals@scrippshealth.org

Fax: (858) 260-5834