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)

☐	Disease Management
☐	Complex Case Management

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

☐	Difficulty controlling symptoms	☐	Medication or treatment non-compliance
☐	Assistance with self-management	☐	Poly-pharmacy
☐	Assistance with care coordination	☐	Poorly controlled chronic conditions
☐	Multiple hospital admissions or ER visits	☐	Caregiver or social issues

Primary diagnosis:

Additional information:

Form with supporting documentation may be emailed/faxed to:
E-Mail: Shpsccmreferrals@scrippshealth.org
Fax: (858) 260-5834