FirstChoice MEDICAL GROUP

Ambulatory Case Management Referral Form

Date		Referral/Auth Number (if applicable)	
Member Name	Date of Birth	Member ID #	
Health Plan/LOB	PCP		
Diagnosis 1	Diagnosis 2	Diagnosis 3	
Referred By		Contact #	
Reason for Referral ☐ Post Hospital Discharge or ER Visit Needs ☐ Current Illness / Disease Process / Diagnosis ☐ Non-Compliant w/ Treatment Plan ☐ Significant Impairment of ADLs / Homebound ☐ Palliative Care Needs / Hospice		☐ In Home Safety Concerns ☐ Frequent Hospital Admissions or ER Visits ☐ Coordination of Care Needs ☐ Other (Please Explain):	
Summarize Reason for Referral and Attach Medical Records			

***Please fax completed form to: Case Management Department**

Fax: (951) 280-8219

Phone (951) 280-7700

Case Management Use Only **HP Referral** ☐

Date Member Contacted	Does Member Meet Criteria? Yes ☐ No ☐
Member Accepts CM? Yes ☐ No ☐	If No, Reason Given
Case Manager	ACM Case Number
Case Referred to Health Plan for Complex CM?	
Comments	