COMMUNITY HEALTH CENTER NETWORK

Basic Case Management (BCM) Referral Form

INSTRUCTIONS

Complete the referral form and attach any supporting clinical documentation.
Please return the completed form via e-mail or fax:

E-mail: **BCM@chcnetwork.org**
Fax: **(510) 297-0450**

For **urgent requests**, please submit your referral to the member's health plan.

Referral Date:

Member Information		
Name (Last, First):		Health Plan ID#:
Date of Birth:	Phone Number:	PCP/Provider:
Address:		
City:	Zip:	
Referring Provider Information		
Contact Name:		
Referring Provider/Facility/Clinic Name:		
Phone#:	E-mail:	
Referral source: ☐Community Partner ☐Hospital ☐PCP ☐Specialty Provider		
Reason for BCM Referral		
☐Care Coordination (e.g., follow-up on authorizations/services, appointments, health navigation and referrals, 3 or less Emergency Department (ED) visits – if more than 3, please refer to the member's health plan) ☐Assist with transition from CA Children's Services (CCS) to Medi-Cal (at 21 years of age) ☐Care with PCP (e.g., follow-ups, community resources, appointments, referrals) ☐Continuity of Care (COC) ☐Assist with coordinating in-network care (e.g., redirect back into network)		
Referral Summary		
Referral Diagnosis (ICD-10): ☐Attached supporting clinical information Situation/Background (including past medical history (PMH), if applicable: Specific action item request(s):		