



PRIMARY PROVIDER MANAGEMENT COMPANY INC.

## Ambulatory Case Management Referral Form

CalCare IPA       Los Angeles Medical Center IPA

Vantage Medical Group-Inland Empire       Vantage Medical Group-San Diego

Date		Referral/Auth Number (if applicable)	
Member Name	Date of Birth	Health Plan/LOB	PCP
Diagnosis 1	Diagnosis 2	Diagnosis 3	
Referred By		Contact #	
Reason for Referral <input type="checkbox"/> Post Hospital Discharge or ER Visit Needs <input type="checkbox"/> Current Illness / Disease Process / Diagnosis <input type="checkbox"/> Non-Compliant w/ Treatment Plan <input type="checkbox"/> Significant Impairment of ADLs / Homebound <input type="checkbox"/> Palliative Care Needs / Hospice		<input type="checkbox"/> In Home Safety Concerns <input type="checkbox"/> Frequent Hospital Admissions or ER Visits <input type="checkbox"/> Coordination of Care Needs <input type="checkbox"/> 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

Date Member Contacted	Does Member Meet Criteria? Yes <input type="checkbox"/> No <input type="checkbox"/>
Member Accepts CM? Yes <input type="checkbox"/> No <input type="checkbox"/>	If No, Reason Given
Case Manager	ACM Case Number
Case Referred to Health Plan for Complex CM?	
Comments	

