PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Referral Date

Care Coordination Referral Form

To contact the Care Coordination Department and refer by phone, please call **(800) 809-1350.**

For inquiries related to Enhanced Care Management, refer to:

Adult ECM Referral Form Children/Youth ECM Referral Form

Referring Practitioner or Facility

Name: Title:

Phone: Fax: Email:

For follow-up communication regarding this referral, check preferred method:

Phone ☐ Fax ☐ Email ☐ Opt out ☐

Name and contact information for follow-up if different from above:

Was the member or authorized representative informed of this referral? ☐ Yes ☐ No

Is the member participating in any other programs? ☐ Yes ☐ No

If yes, please describe: (CCS, CBAS, etc)

Member Information

Member's Name: Member CIN #:

DOB: Gender: ☐ Male ☐ Female ☐ Other

Phone: Preferred Spoken Language:

Street Address:

City, State, Zip: County:

PCP: Phone: Fax:

Specialist: Phone: Fax:

Diagnosis: If pregnant, EDD:

Most recent hospitalization date: Name of Hospital:

Please provide a brief description of why the member is being referred:

In all programs, we practice patient confidentiality at all times.

Partnership HealthPlan of California

4665 Business Center Drive, Fairfield, CA 94534