Case and Disease Management (CMDM) – Program Referral Form

The Alameda Alliance for Health (Alliance) Case and Disease Management (CMDM) Program Referral Form is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please mail, send by a secure email*, or fax the completed form to:
   Alameda Alliance for Health
   ATTN: Case and Disease Management Department (CMDM)
   1240 South Loop Road, Alameda, CA 94502
   Secure Email*: **deptcmdm@alamedaalliance.org**
   Fax: **1.510.747.4130**
   If you have questions about how to send a secure email, please visit **www.alamedaalliance.org.*

For questions, please contact the Alliance CMDM Department via email or call toll-free at **1.877.251.9612**.
PLEASE NOTE: The Alliance will directly notify the member which CMDM program can provide them with services.

Request Date (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

Last Name: _____ First Name: _____

Facility/Clinic/Organization Name: _____

Phone Number: _____ Fax Number: _____

Referral Source (please select only one (1)): ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider ☐ Other (specify): _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Alliance Member ID #: _____ Date of Birth (MM/DD/YYYY): _____

Phone Number: _____ Sex: ☐ Female ☐ Male

Address *(or location, i.e., under 5th St. bridge)*: _____

City: _____ State: _____ Zip: _____

Is the member aware of this referral? ☐ Yes ☐ No

Did the member consent to this referral? ☐ Yes ☐ No

SECTION 3: PROGRAM REFERRAL

Program per referral form (please select only one (1)):

- ☐ Asthma Disease Management
- ☐ Behavioral Health (BH) (including coordination with mental health and Applied Behavioral Analysis (ABA) services)
- ☐ Cardiovascular Disease Management
- ☐ Case Management *(including Complex Case Management (CCM), Care Coordination, and Transitional Care Services (TCS))*
- ☐ Depression Disease Management
- ☐ Diabetes Disease Management
- ☐ Enhanced Care Management (ECM)
- ☐ Other *(please provide details in Section 4)*

SECTION 4: REASON FOR REFERRAL

Situation/background *(including past medical history (PMH), if applicable, and attach supporting documents within the past 30 days)* and any additional information you would like to communicate*:*

FOR BEHAVIORAL HEALTH REFERRALS ONLY:

SECTION 5: DIAGNOSIS

ICD-10	Description:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

SECTION 6: REFERRAL INFORMATION

Service Requested:

Select the preferred referral for a behavioral health care provider (please select only one (1)):

- ☐ Refer to the first available behavioral health care provider
- ☐ Refer to a specific in-network Alliance behavioral health care provider
  Behavioral Health Care Provider Full Name: _____

Mental Health Evaluation/Services

Is the referral a member request? ☐ Yes ☐ No

Has the member previously taken behavioral health medication? ☐ Yes ☐ No

Is the member currently taking behavioral health medication? ☐ Yes ☐ No

Is the member currently in psychotherapy (talk therapy)? ☐ Yes ☐ No

Behavioral Health Care Treatment/Evaluation Services for Autism Spectrum Disorder (ASD)

Select the following services based on the member's needs (please select all that apply):

- ☐ Additional assessment services
- ☐ Autism evaluation and/or Behavioral Health Therapy (BHT)/ABA
  (If selected please complete the attached BH Care – Autism Evaluation, BHT/ABA Referral Form)
- ☐ Speech assessment/therapy
- ☐ Other (specify): _____

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm, at **1.510.747.4567** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**).