HealthPlan OF SAN MATEO

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

Complex Case Management Program Referral Form

Please fax this completed form with any pertinent health records to **650-829-2047.**
To speak with HPSM Care Coordination or refer by phone, please call **650-616-2060.**
To request health education materials for your patient, please call **650-616-2165**.

Referral Date

REFERRING PRACTITIONER OR FACILITY

Name: First MI Last

Title:

Phone:

Fax:

Email:

Check to indicate a referal for Managed Long-Term Services and Supports (MLTSS)

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

MEMBER INFORMATION

Members Name: First MI Last

DOB:

Gender: Male Female

Member ID#:

HPSM Plan: CareAdvantage CMC
HPSM Medi-Cal

Phone:

Language:

Street Address:

City, State Zip:

PCP: name of members primary care physician

Phone:

Fax:

Specialist: name of specialist, if applicable.

Phone:

Fax:

Diagnosis(s):

Date of most recent hospitalization:

Name of hospital:

Brief description why member is being referred:

All referrals are evaluated for eligibility criteria before program admission.
In all programs, patient confidentiality is observed at all times.
Please transmit with a confidential fax cover sheet.

OFFICE USE ONLY

PROCESSED BY:

RECEIVED:

SENT: