HealthPlan OF SAN MATEO
Healthy is for everyone

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

Phone: Language:

Street Address:

City, State Zip:

Member ID#:

HPSM Plan: ◯ CareAdvantage CMC
◯ HPSM Medi-Cal

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: