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

Pediatric Case Management and Requests Form

Please send form to HPSM's Care Coordination/Integrated Care Management team.
By email: carecoordinationrequests@hpsm.org **By fax:** 650-829-2060 **By phone:** 650-616-2060

Member Information

Member's name:	Date of birth:
Sex at birth:	Gender:
HPSM ID# (if known):	Country of birth:
Caregiver (select one): ☐ Parent ☐ Legal Guardian	Caregiver name:
Does member live with caregiver?: ☐ Yes ☐ No. If no, please explain and specify relationship to member: _____	
Member phone (best contact number):	Member email:
Member street address:	Mailing address (if different):
Member's preferred language(s):	Caregiver's preferred language(s):
Is the member and/or caregiver aware of this referral?: ☐ Yes ☐ No **(*IF NO, PLEASE STOP AND RECEIVE INFORMED CONSENT FROM THE MEMBER AND/OR CAREGIVER BEFORE SUBMITTING A REFERRAL)**	
Is member under conservatorship? ☐ Yes ☐ No If yes, name and best contact information:	

Member's Health History and Referral Reason (please include any supporting documents with this referral form)

PCP name:	Phone:	
Specialist name:	Specialty:	Phone:
Is member currently receiving any school-based or outpatient therapies? ☐ Yes ☐ No If yes, please specify (i.e. Speech therapy, occupational therapy, etc., and schedule of therapy):		
Is member connected to any other special programs? ☐ Yes ☐ No If yes, please specify (ie. GGRC, CCS, etc.):		
Diagnosis/diagnoses:		

Referral reason. Please check all that apply, then please note any additional information:
☐ **Member is being referred for complex care management, please list reason(s) why:** _____
☐ Member needs resources and information about specific health condition(s): _____
☐ Looking for health education classes, please specify: _____
☐ Assistance following up on a referral to outpatient therapy, please specify: _____
☐ Information about community resources, please specify: _____
☐ Assistance coordinating short-term care needs (ie. making appointments, etc., please specify: _____
☐ Assistance scheduling transportation to/from medical appointments
☐ Questions about medication
☐ Information about HPSM-covered benefits
☐ Other, please specify: _____

Referred By

Referring party's name:	Relation to member:
Clinic/office/agency name:	Phone number:
Email:	Person HPSM should contact regarding this referral, if different from above (name, relationship, best contact info):

- For general benefit questions, please call HPSM Customer Support at 1-800-750-4776 or 650-616-2133 M-F 8:00AM-6:00PM.
- For behavioral health questions, please call the Behavioral Health and Recovery Services ACCESS Call Center 800-686-0101 available 24/7.
- Please be specific in request and provide as much information as possible to ensure prompt follow-up of your referral/request.