Aetna Better Health of California
10260 Meanley Drive
San Diego, CA 92131

# Aetna Better Health of California

## Case Management Referral Form

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|---|---|---|
| **Member Name:** | **DOB:** | **Referral Date:** |
| **Insurance Plan:** | **Member ID Number:** | **COB:** ☐ Yes ☐ No |
| **Member's Current Phone Number:** | **POA/Guardian Name & Phone Number:** | **Member aware of Referral?** ☐ Yes ☐ No |

**Referred by:**

☐ BH UM
☐ BH CM
☐ Member Advocate
☐ Medical CM
☐ Medical Director
☐ MS
☐ PA
☐ Medical UM
☐Provider
☐ Pharmacy
☐ Other

**Referral to:**

☐ Adult Team – CM
☐ Peds Team – CM
☐ Perinatal CM
☐ Other: Specify

**Concerns leading to referral:** (check all that apply)

☐Transplants
☐Chronic Pain
☐Cancer (new Dx or treatment)
☐Complex/multiple surgery
☐HIV/AIDS
☐Lead Exposure
☐Sickle Cell Anemia
☐Children in Foster Care or in Foster Adoption Subsidy
☐Suicidal/Homicidal Ideation/Hx of
☐Unable to Navigate System on own
☐Court Ordered Treatment
☐Pregnancy with Serious Mental Illness/Substance Abuse
☐Cardiovascular/Stroke complications
☐Respiratory failure/complications
☐Dementia with current complications
☐Pregnancy
☐Diabetic
☐Child w/ Special needs – Specify:
☐Anxiety Disorders
☐Member transitioning onto/off of the plan (transition of care)
☐Serious Mentally Ill Diagnosis
☐Lack of Support and/or Resources
☐Eating Disorder
☐TBI/Seizure disorder
☐Eating Disorder with medical complications
☐Complex Medical Treatment
☐Medical trauma/burns
☐Hepatitis
☐Pervasive Developmental Disorders
☐Pervasive Developmental Disorders
☐Domestic Abuse
☐Substance Abuse
☐Mental Health/Substance Abuse
☐Repeated non-compliance with Meds or Tx Pain
☐Excessive ER use

| | | |
|---|---|---|
| ☐Kidney/liver medical complications | ☐AMA Discharge | ☐2 or more IP admits within 6 months<br>☐Postpartum Depression |
| **Indicate any treatment barriers:** | ☐Housing<br>☐Provider availability<br>☐No Phone<br>☐Lack of Support | ☐Transportation<br>☐Physical Limitations<br>☐Financial<br>☐Other |
| **Current Diagnosis if known:** | | |
| **Current Medications if known:** | | |
| **Important case details:** | | |
| **Discharge Plan if Inpatient:** | | |
| **Current PCP & Phone Number:** | | |
| **Current Specialists & Phone Number:** | | |
| **Referral:** ☐ Accepted ☐Denied | | |
| **Date:** | **CM Assigned:** | |
| **Decision & Date of Notification to Referral Source:** | | |