



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	
Name: _____	
Facility/Clinic Name: _____	
Phone Number: _____	Fax Number: _____
Referral Source: <input type="checkbox"/> Community Partner <input type="checkbox"/> Hospital <input type="checkbox"/> PCP <input type="checkbox"/> Specialty Provider	
<input type="checkbox"/> Other: _____	
SECTION 2: MEMBER INFORMATION	
Last Name: _____	First Name: _____
Alliance Member ID #: _____	Date of Birth (MM/DD/YYYY): _____
Phone Number: _____	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Address (or location, i.e., under 5 th St. bridge): _____	
City: _____	State: _____ Zip: _____
SECTION 3: PROGRAM REFERRAL	
Please select one (1) program per referral form:	
<input type="checkbox"/> Case Management (including Complex Case Management (CCM), Care Coordination, and Transitional Care Services (TCS))	
<input type="checkbox"/> Asthma Disease Management	<input type="checkbox"/> Depression Disease Management
<input type="checkbox"/> Cardiovascular Disease Management	<input type="checkbox"/> Diabetes Disease Management
<input type="checkbox"/> 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): _____ _____ _____	

This fax (and any attachments) is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone or fax and destroy all copies of the original message (and any attachments).

For all other member requests, please call the Alliance Member Services Department, Monday – Friday, 8 am – 5 pm, at **1.510.747.4567**.