



## 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](mailto:deptcmdm@alamedaalliance.org)  
Fax: **1.510.747.4130**

*\*If you have questions about how to send a secure email, please visit [www.alamedaalliance.org](http://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**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Facility/Clinic/Organization Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Referral Source (please select only one (1)): ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider  
☐ Other (specify): \_\_\_\_\_

### **SECTION 2: MEMBER INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Alliance Member ID #: \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Sex: ☐ Female ☐ Male

Address (or location, i.e., under 5<sup>th</sup> St. bridge): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Is the member aware of this referral? ☐ Yes ☐ No

Did the member consent to this referral? ☐ Yes ☐ No

### **SECTION 3: PROGRAM REFERRAL**

Program per referral form (please select only one (1)):

- ☐ Asthma Disease Management
- ☐ Behavioral Health (BH) (including coordination with mental health and Applied Behavioral Analysis (ABA) services)
- ☐ Cardiovascular Disease Management
- ☐ Case Management (including Complex Case Management (CCM), Care Coordination, and Transitional Care Services (TCS))
- ☐ Depression Disease Management
- ☐ Diabetes Disease Management
- ☐ Enhanced Care Management (ECM)
- ☐ 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) and any additional information you would like to communicate:

#### FOR BEHAVIORAL HEALTH REFERRALS ONLY:

#### SECTION 5: DIAGNOSIS

ICD-10	Description:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

#### SECTION 6: REFERRAL INFORMATION

##### Service Requested:

Select the preferred referral for a behavioral health care provider (please select only one (1)):

- ☐ Refer to the first available behavioral health care provider  
☐ Refer to a specific in-network Alliance behavioral health care provider

Behavioral Health Care Provider Full Name: \_\_\_\_\_

##### Mental Health Evaluation/Services

Is the referral a member request? ☐ Yes ☐ No

Has the member previously taken behavioral health medication? ☐ Yes ☐ No

Is the member currently taking behavioral health medication? ☐ Yes ☐ No

Is the member currently in psychotherapy (talk therapy)? ☐ Yes ☐ No

##### Behavioral Health Care Treatment/Evaluation Services for Autism Spectrum Disorder (ASD)

Select the following services based on the member's needs (please select all that apply):

- ☐ Additional assessment services  
☐ Autism evaluation and/or Behavioral Health Therapy (BHT)/ABA  
(If selected please complete the attached BH Care – Autism Evaluation, BHT/ABA Referral Form)  
☐ Speech assessment/therapy  
☐ Other (specify): \_\_\_\_\_

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** or toll-free at **1.877.932.2738** (people with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**).

Questions? Please contact the Alliance Case and Disease Management Department

Phone Number: **1.877.251.9612**

**www.alamedaalliance.org**