Enhanced Care Management (ECM)
Approval Request Form

The Alameda Alliance for Health (Alliance) Enhanced Care Management (ECM) Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for ECM services, please complete the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Attach a clinical summary and/or supporting documentation (ex. clinic notes, hospital discharge summary, etc.), providing justification for ECM.
3. Please fax or send by secure email the completed form to the Alliance Enhanced Case Management Department at **1.510.995.3725** or **ECM@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed.

SECTION 1: REQUESTING PROVIDER INFORMATION

Full Name: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Office Contact Name: _____ Date of Referral: _____

SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Patient's Qualifying Condition(s) (please select all that apply, must meet all requirements in one (1) of the Options to be eligible):

☐ Option 1 (must meet all A. B., and C.):

☐ **A.** Has at least one (1) complex physical, behavioral, or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

Please select all that apply:

- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Chronic Heart Failure (CHF)
- ☐ Chronic Kidney Disease (CKD)
- ☐ Chronic Liver Disease
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Coronary Artery Disease (CAD)
- ☐ Dementia
- ☐ Developmental Disability
- ☐ Diabetes
- ☐ Hypertension
- ☐ Major Depression Disorder
- ☐ Psychotic Disorders
- ☐ Serious Emotional Disturbance (SED)
- ☐ Serious Mental Illness (SMI)
- ☐ Substance Use Disorder (SUD)
- ☐ Traumatic Brain Injury (TBI)
- ☐ Other (please specify): _____

☐ **B.** Had Emergency Department (ED) visits, hospitalizations, or medical encounters.

☐ **C.** Meets the Housing and Urban Development (HUD) definition of homeless as defined in section 91.5 of Title 24 of the Code of Federal Regulations: **www.dhcs.ca.gov/Documents/MCQMD/ILOS-Policy-Guide-September-2021.pdf**

☐ Option 2 (please select all that apply):

☐ **A.** Adults with:

- ☐ Five (5) or more Emergency Department (ED) visits in a six (6)-month period.
- ☐ Three (3) or more inpatient (IP) or skilled nursing facility (SNF) unplanned admits in a six (6)-month period.

☐ Option 3 (must meet all A. **AND** B., ***OR*** B. **AND** C.):

☐ **A.** Eligible to receive services by Alameda County Behavioral Health and/or Drug Medi-Cal Organized Delivery System.

☐ **B.** Actively experiencing at least one (1) complex social factor influencing their health.

☐ **C.** At least one (1) of the following:

- ☐ Two (2) or more psychiatric emergency services (PES) visits
- ☐ Two (2) or more psychiatric inpatient (IP) admits
- ☐ Two (2) or more psychiatric subacute admits
- ☐ Pregnant/post-partum
- ☐ Crisis/ER/IP/Urgent Care utilization with no medical/behavioral health office/ clinic visits

For Internal Use Only:

Is the member linked to (if appropriate):

- ☐ Regional Center of the East Bay (RCEB)
- ☐ California Children's Services (CCS)