



## 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: _____	<input type="checkbox"/> Home <input type="checkbox"/> 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> Bipolar Disorder                             | <input type="checkbox"/> Hypertension                        |
| <input type="checkbox"/> Chronic Heart Failure (CHF)                  | <input type="checkbox"/> Major Depression Disorder           |
| <input type="checkbox"/> Chronic Kidney Disease (CKD)                 | <input type="checkbox"/> Psychotic Disorders                 |
| <input type="checkbox"/> Chronic Liver Disease                        | <input type="checkbox"/> Serious Emotional Disturbance (SED) |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Serious Mental Illness (SMI)        |
| <input type="checkbox"/> Coronary Artery Disease (CAD)                | <input type="checkbox"/> Substance Use Disorder (SUD)        |
| <input type="checkbox"/> Dementia                                     | <input type="checkbox"/> Traumatic Brain Injury (TBI)        |
| <input type="checkbox"/> Developmental Disability                     | <input type="checkbox"/> 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: **42 U.S.C. 11302 - General definition of homeless individual - Content Details - USCODE-2010-title42-chap119-subchapl-sec11302 (govinfo.gov)**

**Option 2 (please select all that apply):**

- A.** Adults with:

- Four (4) or more Emergency Department (ED) visits in a 12-month period.
- Two (2) or more inpatient (IP) or skilled nursing facility (SNF) unplanned admits in a 12-month period.

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