



Case Management Programs Referral Form

Thank you for your interest in referring your Alameda Alliance for Health (Alliance) member patients to our case management program.

INSTRUCTIONS

1. Please return the completed form via mail or fax:
Alameda Alliance for Health
Attn: Case and Disease Management Department
1240 South Loop Road, Alameda, CA 94502
Toll-Free: **1.877.251.9612** | Fax: **1.510.747.4130**

NOTE: The Alliance will directly notify the member if they are selected for a case management program.

REQUEST DATE (MM/DD/YYYY): _____

SECTION 1: REFERRING PROVIDER INFORMATION

NAME: _____
FACILITY/CLINIC NAME: _____
PHONE NUMBER: _____ FAX NUMBER: _____
REFERRAL SOURCE: ☐ Community Partner ☐ Hospital ☐ PCP ☐ Specialty Provider
☐ Other: _____

SECTION 2: ALLIANCE 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 5th Street bridge): _____
CITY: _____ STATE: _____ ZIP: _____

SECTION 3: REFERRAL INFORMATION

REASON FOR REFERRAL (***please attach supporting/clinical documents from the past 30 days***):
For behavioral health referrals, please call Beacon toll-free at **1.855.856.0577**.

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**.