



CBAS REFERRAL FORM

- ROUTINE
 EXPEDITE

DATE RECEIVED

Tel: 510-747-6213
Fax: 510-747-4213

1) Print clearly in blue or black ink. 2) Attach Medical Necessity Form. 3) Fax or mail original to above.

| A. REFERRAL SOURCE INFORMATION | | | |
|-------------------------------------------------------------------------------------------|---------------|------------------------------------------------------|-------|
| REQUEST DATE | SUBMITTED BY: | CONTACT PHONE # | |
| ADDRESS | | CITY, STATE, ZIP | FAX # |
| Medical Necessity Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No | | REASON (only if Medical Necessity Form not attached) | |

| B. MEMBER INFORMATION | | | | |
|-----------------------|----------------------------------------------------------------------------|------|------|-----|
| MEMBER NAME | | DOB | AGE | SEX |
| ADDRESS & CITY | | | ZIP | |
| AAH ID # | <input type="checkbox"/> MEDI-CAL <input type="checkbox"/> MEDICARE/ACC | CIN# | SSN# | |

| C. REQUESTED SERVICE | |
|---------------------------------------------------------|-------------------|
| <input type="checkbox"/> CBAS Eligibility Determination | |
| ICD-10 CODE(S) | PRIMARY DIAGNOSES |
| SPECIAL CONSIDERATIONS: | |

| D. SIGNATURE OF REQUESTER (REQUIRED) | | |
|--------------------------------------|-------------|-------|
| SIGNATURE: | PRINT NAME: | DATE: |

FOR INTERNAL USE ONLY

- Phone Contact attempts: Dates: 1) _____ 2) _____ 3) _____
- Date CEDT Scheduled: _____

Referral Received by: _____ Signature: _____ Date: _____

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