ALAMEDA Alliance FOR HEALTH
Health care you can count on. Service you can trust.

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? ☐ Yes ☐ No	REASON (only if Medical Necessity Form not attached)	

B. MEMBER INFORMATION

MEMBER NAME	DOB	AGE	SEX
ADDRESS & CITY		ZIP	

AAH ID #	☐ MEDI-CAL ☐ MEDICARE/ACC	CIN#	SSN#

C. REQUESTED SERVICE

☐ 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: _____