Case Management Referral Form

Please fax or email with any pertinent health records to **Medicare and Duals members:** 833-741-3193 or email CM_Escalations_Medicare_CA@molinahealthcare.com.

Referring Party Information

Name:	Title:
Phone:	Fax:
Email:	Referral Date:
Was member or authorized representative informed of this referral? ☐ Yes ☐ No	
Comments:	

Member Information

Member Name:	Member ID #:	
DOB:	Phone:	
Street Address:	City, Zip:	
PCP:	Phone:	Fax:
Specialist:	Phone:	Fax:

Referral Reason

☐General Care Coordination	☐Long-Term Support Service (LTSS)
☐ABA/BHT Services – Applied Behavior Analysis/Behavioral Health Treatment	☐CCS/Regional Center Services
☐Behavioral Health Care Coordination	☐CHP (For Medicare only)
☐Other:	
Relevant Clinical Information:	
Comments:	

Thank you for the referral and your partnership in supporting Molina members.