Scripps Health Plan Services
Care Management Referral Form

Date of Referral:

Member's first name:		Member's last name:	
Member ID:		DOB:	
Mailing address:			
Phone number:			

Type of Care Management services needed: (check one)

☐	Disease Management
☐	Complex Case Management
☐	Maternity Health Program

Reason for Care Management Services: (check all that apply)

☐	Poorly controlled chronic conditions	☐	Medication or treatment non- compliance
☐	Assistance with self-management	☐	Polypharmacy
☐	Assistance with care coordination	☐	High risk pregnancy
☐	Multiple hospital admissions or ER visits	☐	Caregiver or social issues
☐	Doula services (prenatal, postpartum, or high-risk pregnancy)		

Primary diagnosis:

Additional information:

Form with supporting documentation may be submitted:
E-Mail: Shpsccmreferrals@scrippshealth.org
Fax: (858) 260-5834