PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Referral Date

Care Coordination Referral Form

Please transmit this form via secured email or fax the completed form with pertinent health records to CCHelpDeskEA@partnershiphp.org or **(530) 351-9088.**
To contact the Care Coordination Department and refer by phone, please call **(800) 809-1350.**
For inquiries related to Enhanced Care Management, refer to the ECM Referral Form.

REFERRING PRACTITIONER OR FACILITY

Name: Title:

Phone: Fax: Email:

For follow-up communication regarding this referral, check preferred method:
Phone ☐ Fax☐ Email ☐ Opt-out ☐
Name and contact information for follow-up if different from above:
Was the member or authorized representative informed of this referral? ☐Yes ☐No
Is the member participating in any other programs? ☐Yes ☐No
If yes, please describe: (CCS, CBAS, etc.)

Member Information

Member's Name: Member CIN#

DOB: Gender:☐ Male ☐Female☐ Other:

Phone: Preferred Spoken Language:

Street Address:

City, State, Zip: County:

PCP: Phone: Fax:

Specialist: Phone: Fax:

Diagnosis: If pregnant, EDD:

Most recent hospitalization date: Name of Hospital:

In all programs, we observe patient confidentiality at all times.

4665 Business Center Drive Fairfield, CA 94534

Please provide a brief description of why the member is being referred:

Partnership Referral Outcomes Note to Provider: