Valley Health Plan

Condition and Complex Case Management Programs

Real Time Referral Form

Date Sent: ____/____/____

☐ **Condition Management Referral**

☐ Asthma ☐ Bipolar Disorder ☐ CAD ☐ CHF ☐ COPD

☐ Depression ☐ Diabetes ☐ Schizophrenia

☐ **Complex Case Management Referral**

Reason for Referral:

_____

_____

Member Information

Name _____ Member's Unique ID# _____

Address _____ City _____

State _____ Zip Code _____ DOB _____/_____/_____

Telephone _____ Gender ☐ M ☐ F

Member's Provider Information

Provider Name _____ ID# _____

Clinic Name (if applicable) _____

Address _____ City _____ State _____

Zip Code _____ Telephone _____ Fax _____

Referral Information

Fax form to: 1.800.542.8074, Attn: VAL Care Management Services Support Service Coordinator

Sent From:

Name _____

Telephone _____