Preferred IPA of California
Be a Preferred Provider

PROVIDER BULLETIN

~ Referrals for Case Management ~

Please see the attached case management referral form.

Criteria for case management referral:

MEDICAL CONDITIONS
Must have 2 or more of these Medical Conditions AND 1 High Risk criteria OR 1 of these Medical Conditions with 2 High Risk Criteria)

- CHF (Stage 3+4 /C+D) or Ejection Fraction <35%)
- COPD w/all of the following: O2 Dependent, on Steroids & Inhaler, Restricted ADLs & multiple ER visits in 6 month period
- CVA with stroke prevention therapy
- Dementia w/comorbities and Dependent for ADLs.
- Diabetes Uncontrolled or HA1C > 12
- End Stage Aids
- Multiple Wound Ulcers
- New onset of paralysis, paraplegia or Quadriplegia (diagnosed within 90 days)

HIGH RISK CRITERIA
****Must have 1 High Risk criteria w/ 2 or more Medical Conditions above or 2 High Risk criteria with at least 1 Medical Condition above)**

- Poor social support
- Poor functional status
- Poor nutritional status
- Continued and documented non-compliance
- More than 2 hospitalizations or more than 3 ER Visits within last 6 months

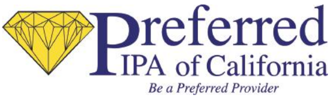
Please also include all recent progress notes, medications, pertinent labs and imaging studies.

Please fax the completed form and progress notes to: 1-818-534-5443.
For questions about case management, please call 1-800-874-2091 and ask for case management.

This case management referral form may be found on our website: www.preferredipa.com

If you have any questions, please contact Provider Relations at (800) 536-2867 Ext. 562.

Phone: 800-536-2867 Fax: 818-265-0801
www.preferredipa.com



CASE MANAGEMENT REFERRAL REQUEST

Fax Referral Request to: (818) 534-5443

DATE SUBMITTED: ____________

CASE MANAGEMENT REFERRAL CRITERIA MET (Select one)

☐ **Patient with 2 or more medical conditions listed below AND 1 High Risk Criteria below**
☐ **Patient with 1 poorly controlled medical conditions below AND 2 High Risk Criteria below**

PLEASE INCLUDE ALL RECENT PROGRESS NOTES, MEDICATIONS, PERTINENT LABS AND IMAGING STUDIES.

Patient Name	Male ☐ Female ☐	DOB	Age
Address	City		Zip
Phone No:	Member Number & Health Plan		
Family/Caregiver Name	Relationship		Phone
PCP Name / Completed by:	MD Signature:		Phone

MEDICAL CONDITIONS

****Must have 2 or more of these Medical Conditions AND 1 High Risk criteria OR 1 of these Medical Conditions with 2 High Risk Criteria)**

☐ CHF (Stage 3+4 /C+D) or Ejection Fraction <35%)
☐ COPD w/all of the following: O2 Dependent,on Steroids & Inhaler,Restricted ADLs & multiple ER visits in 6 mo period
☐ CVA with stroke prevention therapy
☐ Dementia w/comorbities and Dependent for ADLs.
☐ Diabetes Uncontrolled or HA1C > 12
☐ End Stage Aids
☐ Multiple Wound Ulcers
☐ New onset of paralysis, paraplegia or Quadriplegia (diagnosed within 90 days)

HIGH RISK CRITERIA

****Must have 1 High Risk criteria w/ 2 or more Medical Conditions above or 2 High Risk criteria with at least 1 Medical Condition above)**

☐ Poor Social Support (please provide explanation below)

____
____
____

☐ Poor Functional Status (please provide explanation below)

____
____
____

☐ Poor Nutritional Status (please provide explanation below)

____
____
____

☐ > Non-Compliance (Defined as: patient having multiple PCP visits once every month for 6 month period and member continues to be non-compliant). Please provide all PCP office visit dates below.

Visit 1 ________ Visit 2 ________ Visit 3 ________ Visit 4 ________ Visit 5 ________ Visit 6 ________

☐ > 2 Hospitalizations or > 3 ER visits in previous 6 months