Care Management Referral Form

Email: edhccmreferral@blueshieldca.com
Fax: (916) 350-6095

Referral Source

Source of referral: ☐ Member/Self ☐ Provider ☐ Blue Shield of California		
Contact name*	Last name:	First name:
Provider name (if applicable):		
Contact phone number*:		
Contact email address:		

***Required fields**

Member information

Member name*	Last name:	First name:	
Preferred name	Last name:	First name:	
Member ID*		Date of birth*:	
Phone number*:		Gender* ☐ Male ☐ Female ☐ Non-binary	
Address:	City:	State:	ZIP code:

***Required fields**

Program

Select one program, as required

☐ Care management	☐ Prenatal	☐ Kidney care
Comments:		

Thank you for your referral