VHP Valley Health Plan

Case Management Programs

Real Time Referral Form

Telephone: 1-669-220-5235

Email: vhpcasemgmt@vhp.sccgov.org

Date of Referral: _____/_____/_____ **Fax to: 1-408-947-4251**

Type of Referral *(Please select appropriate box below):*

Complex CM: ☐ Condition CM: ☐ ASD CM: ☐

☐ Asthma	☐ CAD	☐ Depression	☐ Bipolar Disorder
☐ CHF	☐ DM	☐ Schizophrenia	☐ Pharmacy
☐ COPD	☐ Mental Health	☐ Others: _____	

Reason for Referrals:

_____

_____

Member Information:

Name: _____ DOB: _____ Age: ____

VMC MR #: _____ VHP ID #: _____

Address: _____

Telephone: (Home) _____ (Cell) _____

Emergency Contact:

Name _____ Phone: _____ Relationship: _____

Member's Provider Information:

Provider Name: _____ Clinic: _____

Address: _____

Telephone: _____ Fax No.: _____

Referral From: _____Department: _____ Tel: _____