UCLA Health | Medicare ADVANTAGE PLAN

Complex Care Management (CCM) Referral Form

The UCLA Health Complex Care Management (CCM) program is designed to support our members in managing their health more effectively. We accept referrals for members who require comprehensive care coordination and management.

Program Overview:

The CCM program aims to assist members by:

- Coordinating complex healthcare needs.
- Providing personalized care plans.
- Offering support and resources to manage chronic conditions.
- Ensuring seamless communication between healthcare providers.

Referral Triggers:

Members may be referred to the CCM program based on the following triggers:

- **Diagnosis Triggers:** Specific medical conditions that require intensive management.
- **Utilization Triggers:** High utilization of healthcare services indicating a need for coordinated care.
- **Provider Triggers:** Recommendations from healthcare providers based on clinical assessments.

Referral Process:

To refer a member to the CCM program, please complete the following steps:

1. **Member Information:** Provide detailed information about the member.
2. **Trigger Identification:** Check all applicable triggers that indicate the need for complex care management.
3. **Contact Information:** Include your contact details for follow-up.
4. **Submission:** Email the completed referral form securely to uclacomplexcmprogram@mednet.ucla.edu.

Thank you for your collaboration in ensuring our members receive the best possible care.

Sincerely,
UCLA Health Complex Care Management Team

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Please fax or email referrals with pertinent health records to UCLA Health Medicare Health Plan's Complex Care Management Team: (818) 516-8177 OR Email to uclacomplexcmprogram@mednet.ucla.edu

Referrer Information

Date of Referral: Referrer Name: Referrer Phone #:

Referrer Type:

- ☐ Member Self-Referral
- ☐ Hospital Staff
- ☐ IPA
- ☐ PCP
- ☐ Specialist
- ☐ UCLA Health Medicare Advantage Plan Team:
- ☐ Other:

Member Information

Member Name: DOB: Preferred Language:

ID#: Cell Phone #: Home Phone #:

PCP Name: PCP Phone #:

Caregiver: ☐ Yes ☐ No

If yes,

Caregiver Name: Caregiver Phone #:

Caregiver Relationship:

Has the member been informed about the CM referral? ☐ Yes ☐ No

Reason for Referral

Referral Reason(s):

- ☐ Health Condition *(multiple uncontrolled chronic conditions, end stage condition, major organ transplant, multiple falls, etc.)*
- ☐ Frequent hospitalizations or emergency room visits *(3 or more hospitalization in past 12 months; 3 or more emergent room visits in the past 6 months, etc.)*
- ☐ Social Needs *(poor social support, housing insecurity, home safety, etc.)*
- ☐ On multiple medications for multiple chronic conditions
- ☐ Projected cost of care within a 12-month period anticipated to be >$100,000 *(including high-cost medications and/or DME)*
- ☐ Other:

Referral Explanation:

Recent Utilization:

- ☐ Hospital or Emergency Room Visits in the last 6 months:
  - Name of Facility:
  - Date of Admission:
  - Admission Reason:
- ☐ Emergency Room Visits
  - Name of Facility:
  - Date of Admission:
  - Admission Reason:

Thank you for your referral and for supporting our UCLA Health Medicare Advantage Members. Your referral will be reviewed and processed within 3 business days.