

FAX/FTP/EMAIL

Whole Child Model (WCM) Eligibility Referral

FORM REQUIRED — THIS DOCUMENT CONTAINS PHI

Health Network:		Provider Name:		Provider NPI:	
Requester/Health Network Contact Information					
Organization:		Name:		Email:	
CalOptima Health Submitter					
Name: Case Management — WCM		Email: cmwcmfax@caloptima.org		Fax Phone: 714-954-2298	
Member Information					
Member Name:			CIN #:		Date of Birth:
CCS Case No (if applicable):					
<input type="checkbox"/> CCS Service Authorization Request Form Attached					
CCS Referral* (Check all that apply)					
<input type="checkbox"/> Initial Medical Eligibility Request (includes NICU infants with a possible CCS eligible diagnosis)					
Potential CCS Condition(s):	ICD-10 Code		Description		
<input type="checkbox"/> Additional Medical Eligibility Request for Active CCS Case					
Existing CCS Condition(s):	ICD-10 Code		Description		
Potential CCS Condition(s):	ICD-10 Code		Description		
<input type="checkbox"/> Medical Therapy Program (MTP) Eligibility Request					
Potential CCS Condition(s):	ICD-10 Code		Description		
<input type="checkbox"/> NICU Acuity					
Birth Weight:		Gestational Age:			
<input type="checkbox"/> HRIF Referral					
NICU Discharge Date:		Gestational Age:			
<input type="checkbox"/> NICU Discharge Summary Attached					
NICU Facility:		Additional Dx:			

* Member's medical records from CCS-paneled specialists caring for the CCS and related CCS conditions that document member's medical history, physical exam, laboratory tests, radiologic findings, and other tests or examinations that support the diagnosis and treatment of the eligible condition(s).