PHONE: (415) 216-0088
FAX: (415) 216-0081
www.AAMGDoctors.com

CASE MANAGEMENT REFERRAL FORM (CMR)

All referrals MUST be faxed to AAMG's/CCHCA's UM Department at (415) 216-0081.

Please fax all supporting medical documentation with this form.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Sex: Male ☐ Female ☐ Date of Birth: _____ Patient's Preferred Language: _____

Health Plan: _____ ID No. _____ Effective Date: _____

PHYSICIAN INFORMATION

Name of Referring Physician: _____

Telephone Number: _____

Fax Number: _____

Reason for Referral:

_____

_____

_____

MEDICAL DIAGNOSES

Diagnosis (ICD-10):	Description:

Additional notes:

_____

_____

_____

_____

Referring Physician Signature: _____ Date: _____

Notes:

1. This form is only for referral purposes for AAMG and CCHCA in-network physicians.
2. For further assistance, please contact provider.relations@aamgdoctors.com or call the AAMG/CCHCA phone number at (415) 216-0088.