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

# CASE MANAGEMENT REFERRAL FORM (CMR)

**All referrals MUST be faxed to AAMG'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: |
|---|---|
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**Additional notes:**

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______________________________________________________________________________________________

Referring Physician Signature: ___________________________________________ Date: ______________________________

**Notes**:

1. This form is only for referral purposes for AAMG in-network physicians.
2. For further assistance, please contact ProviderRelationsNorCal@networkmedicalmanagement.com or call AAMG at (415) 216-0088.