vivanthealth

Vivant Health Member Relations Referral Form

Member name: ______________________________

Member ID: ______________________ Date of birth: ______________________

Authorization number, if applicable: ______________________

Address: ______________________________

City: ______________________ State: __________ ZIP: __________

Home phone number: ______________________ Mobile number: ______________________

Email address: ______________________________

Language spoken: ☐ English ☐ ASL ☐ Translator needed Language: ______________

Preferred method of communication: ☐ Phone call ☐ Text ☐ Mail ☐ Email

Responsible party/alternate contact: ______________________ Phone number: ______________

Name of referrer: ______________________

Special notes: ______________________________

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Member Access Issues

Does the member need help understanding their Medi-Cal benefits? ☐ Yes ☐ No

Does the member need help with transportation to and from appointments? ☐ Yes ☐ No

How many ER visits has the member had in the last 12 months? __________

Is the member able to make ends meet at the end of the month? ☐ Yes ☐ No

Does the member need help accessing healthy and nutritious food? ☐ Yes ☐ No

Is the member concerned about the quality of housing they are living in? ☐ Yes ☐ No

Does the member need help paying for utilities? ☐ Yes ☐ No

For Office Use Only:

Date received: ______________

Member relations specialist assigned to case: ______________________________

Action plan: ______________________________

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Please fax referral form to **(916) 848-3596**.
Once received, the Member Relations Department will respond within 2 business days.

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