Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

DISEASE MANAGEMENT PROGRAM PROVIDER REFERRAL FORM

MEMBER INFORMATION

Member's Full Name _____

Member's Date of Birth _____

Member's Preferred Phone Number _____

Member's CIN Number _____

REFERRAL INFORMATION

Your Name _____

Your Contact Information _____

Date of Referral _____

CHECK ALL BOXES THAT APPLY

- ☐ Asthma
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Pre-Diabetes

Member has needs related to:

- ☐ Education about the condition
- ☐ Self-management
- ☐ Medication adherence
- ☐ New diagnosis

COMMENTS

Thank you for your referral. Please send the completed form via fax to 1-855-883-1552 or email to DM@goldchp.org.
If you have any questions, please call the Disease Management Department at 1-805-437-5694.