Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

ASTHMA REMEDIATION MEMBER REFERRAL FORM

External referral by *(select one)*: ☐ **Hospital** ☐ **Participating Medical Group (PMG)** ☐ **Primary Care Physician (PCP)** ☐ **Clinic** ☐ **Enhanced Care Management (ECM)** ☐ **Other**

FAX: 1-855-883-1552 PHONE: 1-888-301-1228 www.goldcoasthealthplan.org

PROVIDER INFORMATION

Name: _____

Organization Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Office: _____

Contact: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Medi-Cal ID: _____ Phone: _____ Email: _____

Birth Date *(Required)*: _____ Age *(Required)*: _____

Best time to contact: _____

CAREGIVER / CARE MANAGER INFORMATION

Caregiver / Care Manager name: _____

Phone: _____ Email: _____

Alternate phone number (if available): _____

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This portion of the document is to be completed by a licensed care provider (MD, PA, NP):

THE MEMBER HAS POORLY CONTROLLED ASTHMA DOCUMENTED BY:
☐ Emergency department visit in the past 12 months ☐ Hospitalization in the past 12 months ☐ Two sick / urgent care visits in the past 12 months ☐ Score of ≤ 19 on asthma control test
Is the home owned, leased, rented, or occupied by the member? ☐ Yes ☐ No
This request is for (check all that apply): ☐ **Equipment:** Allergen-impermeable mattress and pillow dust covers; High-Efficiency Particulate Air (HEPA) filtered vacuums; dehumidifiers; air filters; asthma-friendly cleaning products and supplies ☐ **Home modification:** Integrated Pest Management (IPM) services; other moisture-controlling interventions; minor mold removal and remediation services; ventilation improvements

NOTE: The lifetime cap for this service is $7,500.

DOCUMENTATION *Please provide a brief written evaluation specific to the member describing how and why the remediation(s) meet(s) the needs of the individual.*

It's recommended that you attach one or more of the following documents with this request:

- Documentation of asthma diagnosis from service provider, Primary Care Provider (PCP), or specialists
- Pulmonary function tests
- Prescriptions
- Asthma treatment plan
- List of asthma medications

Licensed Care Provider Signature: _____ Date: _____