

To refer a Molina member for health education services:

1. **Complete all requested information (please print clearly).**
2. **Fax or E-mail** the completed referral form to Molina at (562) 901-1176 or MHIHealthEducationMailbox@MolinaHealthCare.com
3. Fax required documentation with all referrals.
4. If you have questions, call (866) 472-9483.

Today's date: _____

Member Information

Last Name: _____	First Name: _____	Member ID/ CIN#: _____
Address: _____		City: _____ Zip Code: _____
Current Phone #: _____	Preferred Language: _____	DOB: _____
Diagnosis: _____		
Full Name of Guardian (if member is under 18 years of age): _____		
Best Time to Call Member: _____		OK to leave messages at home: <input type="checkbox"/> YES <input type="checkbox"/> NO

PCP Information

Name: _____	IPA/Medical Group Name: _____
Address: _____	
Phone Number: _____	Ext: _____ Fax Number: _____

Educational Need (check one only)

Attach: Recent Progress Notes and Labs

☐ COPD

☐ CVD (Cardiovascular Disease): Coronary Artery Disease, Congestive Heart Failure, High Blood Pressure

☐ Diabetes Program (ages 18 and over)

☐ Asthma Program

☐ Smoking Cessation Program

☐ Pregnancy Program EDC: _____

☐ Substance Use — Specify: _____

☐ Mental Health — Specify: _____

☐ Pediatric Weight Kits (ages 16 and below)

☐ Adult Weight Management (Weight Watchers® program, ages 17 and older only)

Height _____ Weight _____ BMI: _____

For a BMI of 40 or higher (obesity class III), it is Molina's policy that the referral contains a signed medical release (physically able to exercise) for the member to participate in the Weight Watchers® Program.

"OK to participate in the Weight Watchers® program:" _____

Physician Signature

Date