CalOptima
A Public Agency
Better. Together.

Health Education *or* Childhood Obesity Prevention and Treatment Program (COPTP)
REQUEST FORM
For CalOptima Members

Date: _____ **Name of Health Network**: _____

Check appropriate box: ☐ Medi-Cal ☐ Healthy Families Program ☐ Healthy Kids

HEALTH EDUCATION

Member Name: _____ CIN: _____

Gender: ☐ Female ☐ Male Age: _____ DOB: _____ Member Phone: _____

Member Address: _____ Apt # _____ City _____ Zip _____

Language Preferred: ☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Other _____

DIAGNOSIS: _____ ICD9 Code: _____

Health Education Topic: _____

If referral is for Nutrition please specify what type of nutrition education being requested:

☐ Weight Management ☐ Diabetes ☐ Other (please specify) _____

What do you want the patient to learn? _____

REQUESTOR

REQUIRED Information: ☐ Physician ☐ Case Manager ☐ Other

Referring Provider: _____ Provider ID: _____

Provider Address: _____ Provider Phone: _____

City/Zip: _____ Provider Fax: _____

Office Contact Person _____ Phone: _____

COPTP REFERRAL ONLY

ADDITIONAL REQUIRED Information for COPTP:

Does member have any Co-morbidities/ Additional Conditions that may be related to obesity:

☐ No ☐ Yes___If Yes, please list all Co-morbidities/conditions below with the ICD9 code:

Date of BMI calculation: _____ **BMI:** _____ **Weight (lb.)** _____ **Height (in.)** _____

Member Diagnosis Based on BMI: (Check primary and secondary codes that apply)

Primary Diagnosis Code:
- ☐ 278.00 Obesity, Unspecified
- ☐ 278.01 Morbid Obesity
- ☐ 278.02 Overweight

Secondary Diagnosis Code:
- ☐ V85.53 BMI ≥ 85th to < 94th percentile ____%
- ☐ V85.54 BMI ≥ 95th percentile

Notes:

Physician Signature (*Required*): _____ **Date:** _____

SEND/ FAX

Fax Referral Form To: 1-714-338-3127

E-MAIL: healthpromotions@caloptima.org **Call for questions:** 1-714-347-3272

(Please note: All e-mails that include PHI must be sent in an encrypted method using a DHCS approved solution.)