



# Referral Form

Complete all fields below and submit completed form to HPI via:

email: **HealthPlansReferralRequest@HealthPlansInc.com**

fax: **508-792-1188**

Patient Name: \_\_\_\_\_

HPI Member ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_

HPHC Provider ID#: \_\_\_\_\_

NPI#: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

ICD-10 Diagnosis Code: \_\_\_\_\_

Telephone#: \_\_\_\_\_

Fax#: \_\_\_\_\_

### Servicing Provider

Name: \_\_\_\_\_

HPHC Provider ID#: \_\_\_\_\_

Address: \_\_\_\_\_

TIN: \_\_\_\_\_

NPI#: \_\_\_\_\_

Participating HPHC Provider?  Yes  No

Number of Visits Requested: \_\_\_\_\_

Requested Service:

Office Visit  Consult

Level of Service:

Elective  Urgent  Emergency

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Payment is based on member eligibility and benefit limitation at the time the service is rendered, as well as Harvard Pilgrim Health Care provider contractual agreement. All services will be subject to applicable copays, coinsurance, and deductibles.

The document accompanying this fax contains information from Health Plans, Inc. (HPI) which is confidential and/or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this transmission is prohibited. If you received this fax in error, please telephone HPI immediately so that we can arrange retrieval of the original documents at no cost to you. You may call HPI at **800-343-7674**.