HealthPlans, Inc.

Referral Form

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

email: **HealthPlansReferralRequest@HealthPlansInc.com**

fax: **508-329-4821**

Patient Name: ____________________ Date of Birth: ____________________	HPI Member ID#: ____________________
Requesting Provider: ____________________	HPHC Provider ID#: ____________________ NPI#: ____________________
Person Completing Form: ____________________ Telephone#: ____________________ Fax#: ____________________	ICD-10 Diagnosis Code: ____________________
Servicing Provider	
Name: ____________________ Address:	HPHC Provider ID#: ____________________ 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.

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