Clear Form

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.