



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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