TO ENSURE TIMELY PROCESSING PLEASE COMPLETE ENTIRE FORM.

Referral Form

Email: HPPSupport@hdis.com | Fax: 833-396-4663

Date: ______________________________

Patient Information (Please Print)

Member Name: ____

Shipping Address: ____

Phone Number: ______________________________ Member DOB: ____________________

HPP Medicare ID#: ____

HPP Medicaid ID#: ____

Please complete the following questions:

YES / NO Patient has a diagnosis of ***uncontrolled hypertension***.

YES / NO Patient is at least 18 years of age.

YES / NO Patient's last blood pressure reading was ≥ 140/90.

YES / NO Blood pressure cuff is being requested to actively monitor patient's blood pressure for potential medication or plan in treatment changes/intervention (e.g., lifestyle modifications, adherence to the treatment recommendations).

YES / NO Patient will report blood pressure readings as directed to his/her provider.

All the above require a "**YES**" response in order to be eligible for blood pressure cuff.

For quality purposes and to support request for blood pressure cuff, remember to include the following **Codes for Blood Pressure Compliance** on your next claims submission:

- *Systolic* ≥ 140 mm Hg: **3077F**
- *Diastolic* ≥ 90 mm Hg: **3080F**

** Your patient is eligible for one blood pressure cuff per calendar during the "emergency pandemic"*

Physician's Information

Physician's Name: ____

Physician's NPI # ____

Office Contact Name: ____

Physician's Phone Number: ____________________ Physician's Fax Number: ____________________

Physician's Signature ____

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