



# Health Partners Plans Confidential Referral for Services

For HPP use only (required):  Medicaid New  Medicaid Additional Round

**Name** (First, MI, Last): \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **Unit Number** (if needed): \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Alt. Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Veteran?**  Yes  No

**Gender:**  Male  Female **Ethnicity:**  Hispanic  Non-Hispanic

**Race** (please check all that apply):  American Indian/Alaska Native  Asian  Black/African American  
 Native Hawaiian/Pacific Islander  White  Other: \_\_\_\_\_

**Language:**  English  Spanish  Other: \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Emergency Contact Phone:** \_\_\_\_\_

**HPP Member ID:** \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_ **Date of Diagnosis:** \_\_\_\_\_

**Secondary Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_ **Date of Diagnosis:** \_\_\_\_\_

**Food Allergies?**  Yes  No Describe: \_\_\_\_\_

**Treatment Plan/Member Goal:** \_\_\_\_\_

**Coexisting Conditions:** \_\_\_\_\_

**Recent Hospitalizations/ER Visits** (Dates/Reasons): \_\_\_\_\_

**Current Height:** \_\_\_\_\_ **Current Weight:** \_\_\_\_\_ **Date Weighed:** \_\_\_\_\_

**Weight History** (including dates): \_\_\_\_\_

**Significant Lab Values** (if available):

Test	Albumin	CD4	Chol.	Glucose	HbA1c	Hgb.	Kidney or Liver Tests	TG
Value								
Date Month/Year								

**Current Medications or Supplements:** \_\_\_\_\_  
\_\_\_\_\_

**Ambulation or Living Environment Concerns:** \_\_\_\_\_

**Provider Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Please email form to [clinicalconnectionsunit@hpplans.com](mailto:clinicalconnectionsunit@hpplans.com).  
For any questions, call HPP at 215-845-4797.

**\*\*Confidential Facsimile \*\***

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