



To submit referrals electronically, sign into your Trading Partner Account through Health PAS Online at [www.idmedicaid.com](http://www.idmedicaid.com)

## Healthy Connections Primary Care Referral Form

(PLEASE PRINT CLEARLY)

### Participant Information:

Date \_\_\_\_\_ Participant Name \_\_\_\_\_

Participant Medicaid #: \_\_\_\_\_ Participant Date of Birth: \_\_\_\_\_

### Referring Primary Care Provider:

Primary Care Provider Organization Name: \_\_\_\_\_

Provider Billing NPI# \_\_\_\_\_

HC Clinic or PCP Name: \_\_\_\_\_

HC Clinic Phone Number: \_\_\_\_\_

### Referral Information

Referral Start Date \_\_\_\_\_ End Date \_\_\_\_\_ (up to 365 days)

AND Visits/Units \_\_\_\_\_ (if applicable)

1. Referred To Provider or Group: \_\_\_\_\_

Provider Billing NPI #: \_\_\_\_\_ Phone Number \_\_\_\_\_

Address: \_\_\_\_\_

*For coordination of care, referred to provider is required to communicate all results/findings back to the primary care provider.*

### Referral Approval Reason—choose one

- Consultation/Diagnosis Only *\* Diagnosis/Condition required to be documented in notes section*
- Diagnose, treat and/or forward to specialty provider
- One-time visit until seen by PCP
- Other- **Must be indicated in notes section**

Notes (Diagnosis/Condition AND Referral Details): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have questions regarding this referral, please contact:

Referral Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_