IDAHO DEPARTMENT OF HEALTH & WELFARE

To submit referrals electronically, sign into your Trading Partner Account through Health PAS Online at 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 #: _____