Disease Management/Population Health Program Referral Form

Thank you for referring your patient(s) to our program. All information contained on this form is strictly confidential and may become part of your patient's record.

Referring physician information	
Referring physician's name:	
Referring physician's phone:	
Referring physician's email:	
Member information	
Member name:	
Member ID:	Member DOB:
Member phone:	
Member email:	
Referral date:	
Health condition:	
Reason for referral:	
Any additional details:	
Member information	
Member name:	
Member ID:	Member DOB:
Member phone:	
Member email:	
Referral date:	

Health condition (See DM eligible conditions on webpage noted below.):	
Reason for referral:	
Any additional details:	
Member information	
Member name:	
Member ID:	Member DOB:
Member phone:	
Member email:	
Referral date:	
Health condition (See DM eligible conditions on webpage noted below.):	
Reason for referral:	
Any additional details:	

Please email this form to DM-PHP-Provider-Referrals@simplyhealthcareplans.com.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.