Health Management Program Referral Form

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800-752-5863
Fax: (605) 328-6840
sanfordhealthplan.com
sanfordhealthplan.com

SANFORD HEALTH PLAN

Member Information

Name: _____ Member ID #:_____ Date of Birth:_____

Address, City, State, Zip:_____

Referring Practitioner Information

Practitioner Name/Clinic: _____

Contact Name: _____

Address, City, State, Zip: _____

Phone Number: _____ Fax Number:_____

Practitioner ID: _____

Health Management Programs

☐ Asthma
☐ Diabetes
☐ Heart Disease (CAD)
☐ Heart Failure
☐ High Blood Pressure

Has member been hospitalized recently? ☐ Yes ☐ No

Reason for Referral/Diagnosis

_____

_____

_____

For Office Use Only:

Date Received: _____ Processed by: _____ Follow-up Date: _____