REFERRAL FORM

Phone: 952-562-1235
Fax: 844-999-1534
NPI: 1881253037
Email: referrals@healthemed.net
Web: healthemed.net

Date

I am a:

- ☐ **Waiver Case Manager | Service Coordinator**
- ☐ **Nurse | Nursing Case Manager**
- ☐ **Family Member | Client**
- ☐ **Other:**

Choose the Product Requested:

☐ **HealtheMed "Clinic at Home™" Telemedicine Platform** | $15/day
*or agreed upon county/state pricing

Client Information:

Name		Date of Birth	
Phone		Member ID / PMI	
Address			
City		State	Zip
Email Address		Language	
Waiver Categories			

Person we can contact to help setup the service(s) requested:

Name		Relationships	
Phone		Organization	

Waiver Case Manager | Service Coordinator:

Name		Phone	
Email		Organization	

What else would you like us to know about the client or referral?

Please complete and email (using your secure email client) to: referrals@healthemed.net OR fax to 844-999-1534.

After submitting the referral form:

1. We will contact you to confirm the referral was received.
2. We will contact the person responsible for approval/filling medications to confirm services/setup.
3. We will follow up with you after everything is set up. Thank you for the referral!

Click here to Submit