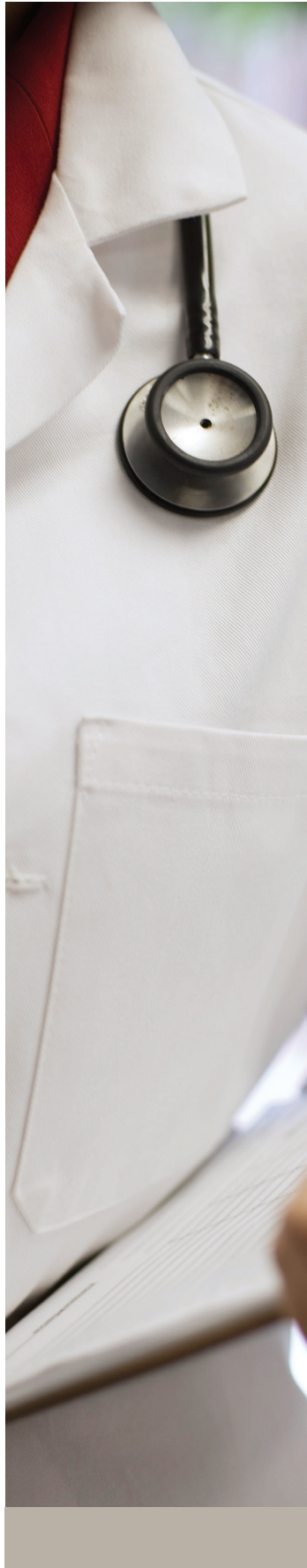


UPMC HEALTH PLAN



Health Management Referral Form

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

Patient Signature: _____

REFERRING INDIVIDUAL:

Name: _____

Title: _____

Practice/Facility: _____

- Referral Type:
- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> CAD | <input type="checkbox"/> CHF | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Other: _____ | | |

Fax form to 412-454-7551
Health Management: 1-866-778-6073