HealthPlan OF SAN MATEO

801 Gateway Blvd., Suite 100 | South San Francisco, CA 94080

CBAS & MSSP Referral Form

Date: _____

Member Name: _____ Phone: _____

Member's Address: (Street City ST Zip) _____ Primary Language: _____

Member's Date of Birth: _____ HPSM ID or Medi-Cal ID (CIN) : _____ Interpreter Required? ◯ Yes ◯ No

Name of Representative: _____ Relationship to Member: _____ Representative's Phone: _____

Type of Referral (select one):

◯ Community Based Adult Services (CBAS)

◯ Multipurpose Senior Services Program (MSSP)

Member was informed of this referral: ◯ Yes ◯ No

Name of Program Requested by Member (CBAS Only):

...

Medical Reason for Referral

Name of Referring Person or Agency: _____ Phone: _____

Mailing Address: _____

Name of Primary Care Physician: _____ Phone: _____ Medical Records Fax: _____

Name of Person Completing Referral Form: _____ Phone: _____

Please fax referrals to HPSM **650.829.2047**

Thank you for your referral

UPDATED December 21, 2017 4:13 PM

RESET FORM PRINT FORM