HEALTH INNOVATION PARTNERSHIPS AND PROGRAMS (HIPP) – DIABETES

REFERRAL FORM

Date of Referral: _____

PARTICIPANT INFORMATION

INSTRUCTIONS: Please, use an ink pen or pencil to complete this form. Then, submit it using one of the ways listed below. If you need help completing or submitting the form or want to make the referral by phone, call us at 219-200-5939 or 800-616-3718 to speak with a person.

Self-referral: If you want to participate in the program, enter information about yourself. We will use the information provided to contact you.

Business referral: If you represent a physician's office or other business entity, enter information pertaining to the person being referred to the program.

Full Name: _____
First **Middle Initial** **Last**

Address: _____
Street Address **Apartment/Unit #**

_____
City **State** **Zip Code** **County**

Primary Phone: _____ **Alternate Phone:** _____

Email: _____

Check all boxes that apply to the person being referred. ☐ Hard of Hearing ☐ Unable to read/write ☐ Limited English language ☐ None or N/A ☐ Other: _____

GO - IF YOU ARE A BUSINESS ENTITY, PLEASE COMPLETE THE SECTION BELOW.
STOP - IF YOU ARE REFERRING YOURSELF, DO NOT COMPLETE THE SECTION BELOW.

Business Name: _____

Business Email: _____ **Business Phone:** _____

Printed Name/Title of person submitting the Referral: _____

Please, submit the Referral form using one of the following options:		If you have questions, contact:
Email	diabetes-support@carestar.com	Danielle Martin-Moody, Supervisor Email: dmoody@carestar.com Phone: 1-219-200-5939
Fax	513-618-8319	
U.S. Mail	CareStar, Inc. ATTN: HIPP 1075 Broad Ripple Avenue #316 Indianapolis, IN 46220	