

ProgenyHealth Maternity Services Patient Referral Form

For HAP Empowered Medicaid, HAP Fully Insured
Commercial, and Henry Ford Health Plan Members

Referral Date: ___/___/_____

MEMBER INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ___/___/_____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: (_____) _____ Mobile Number: (_____) _____

Last Menstrual Period (LMP): ___/___/_____ Estimated Date of Delivery: ___/___/_____

Gravida _____ Para _____

Insurance information

Health Plan: _____ Subscriber ID: _____

PROVIDER INFORMATION

Name: _____ Practice Name: _____

Address: _____ Suite #: _____

City: _____ State: _____ ZIP: _____

Main Number: (_____) _____ Fax Number: (_____) _____

Provider Specialty:

- OB/GYN Maternal-fetal Specialist Midwife/Doula
 Family Practitioner Internal Medicine Other: _____

Reason for referral to ProgenyHealth Maternity Services:

- High-Risk Diagnosis – Specify: _____
 Maternal Mental Health Concerns – Specify: _____
SDoH concerns: Financial Strain Housing Concerns Transportation Barriers
 Domestic Violence Other: _____

SECURE FAX TO:
866.469.4868

PROGENYHEALTH
450 Plymouth Road, Suite 200 • Plymouth Meeting, PA 19462
Toll-free: 1-855-231-4730 • 8:30AM – 5:00PM Monday – Friday

