CONTACT REQUEST FORM

Facility name (if applicable): ______________________________

Medical Requesting Team (if applicable): ______________________________

The Medicaid/Medicare-eligible individual listed below has given permission to have a HealthPartners sales agent call to discuss HealthPartners Special Needs Plans (SNPs). Please contact the beneficiary listed below.

REQUESTOR
Organization:
Requester or contact name:
Phone number:
PLEASE CONTACT BENEFICIARY OR AUTHORIZED REPRESENTATIVE
Beneficiary name:
Beneficiary date of birth:
Authorized representative (if applicable):
Phone number:
Address:
City, state, zip code:
Preferred method of contact: ☐ Phone Call ☐ Mail ☐ E-Mail
Email Address (if selected method above):
LTC facility:
I give permission for a representative to call me: ☐ Yes ☐ No
Notes:

Email, mail or fax completed forms to DeAnna Hoien:

deanna.l.hoien@healthpartners.com
HealthPartners Medicare Sales: 21102A
8170 33 Ave. S.
Bloomington, MN 55425
Fax: **952-853-8718**

Questions? Call DeAnna Hoien at **952-883-6755**

This form is not intended to be distributed to or completed solely by the beneficiary or their authorized representative. HealthPartners is a health plan with a Medicare contract.

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