Health Net® Quest HealthConnect™

Quest HealthConnect Referral Form

Please review the referral information below. Select the corresponding option from the service information section, then sign and date in the Primary Care Physician section and fax back to 888-353-6442.

All required fields are noted with an asterisk (**) for your convenience.

Member Information	
Health plan name	
Subscriber ID	
Patient name	
Patient date of birth (DOB)	
Patient address	
Patient phone number	
I authorize the patient above for the following service:	
☐	**HbA1c Test**
☐	**Child and Adolescent Well-Care (WCV) Visit for ages 18–21**
Primary Care Physician/Referring Provider Information	
Provider name	
Provider address	
Provider phone number	
Provider fax number	
****Provider signature**	
****Date**	

Please fax completed referral form to: 888-353-6442.

A fax cover sheet must accompany all fax transmissions of protected health information. The cover sheet must be labeled “PROTECTED HEALTH INFORMATION.”