UnitedHealthcare Community Plan

Referral Request Form

To request a referral, please have the UnitedHealthcare Community Plan member's assigned primary care provider (PCP) complete, sign and submit this form. Fax the form to **888-624-2748.** Thank you.

Member

Name: (Last, First, MI):	
Member Health Plan ID:	Phone: ( )
Date of birth (MM/DD/YYYY):	
Address (Street, City, State, ZIP Code):	

Referring PCP

Name (Last, First, MI):	Phone: ( )
Tax ID Number:	Fax: ( )
Address (Street, City, State, ZIP Code):	

We apologize that the self-service UnitedHealthcare Community Plan referrals tool is not available online. If you tried to use the referralLink and it didn't work for you, please note the error code you received below:

_____.

Specialist/Rendering Care Provider

Name (Last, First, MI):	Specialty:
Tax ID Number:	Phone: ( )
Address (Street, City, State, ZIP Code):	

Referral Request Information

Service requested: ☐ Routine referral ☐ Standing referral	(NOTE: maximum duration of six months) Routine referral - maximum six visits Number of visits requested: _____ If blank, one visit is assumed.	Routine service start date:_____ Routine service end date:_____ Standing referral start date:_____
Diagnosis with code (List at least one, not more than two):		
_____ Signature of referring PCP		_____ Today's Date