Primary Care Physician Referral Form

UnitedHealthcare Community Plan

Print or type in black ink.
Please complete this form when you need to refer your patient for care and refer them only to contracted care providers with UnitedHealthcare Community Plan. If you have questions, please call Provider Services at **800-445-1638.**

1. Member Information

Member's Health Plan ID Number/AHCCCS Number	Member Name (Last, First, MI)
Member's Health Plan Group Number	Member Birth of Date

2. Primary Care Provider Information

Member's Primary Care Physician (PCP) Name	PCP Tax ID # /National Provider Identifier # (TIN/NPI)
PCP Address (include City, State and ZIP code)	PCP Phone/Fax Number

3. Consulting/Referring Care Provider Information

Consulting Care Provider Name	Consulting Care Provider TIN/NPI
Consulting Care Provider Address (include state and ZIP code)	Consulting Care Provider Phone/Fax Number

4. Other Insurance Coverage Information (COB):

Does the patient have other insurance coverage □ Yes □ No If yes, please indicate coverage: □ Medicare □ Motor vehicle accident □ Workers' Comp □ Commercial

5. Member Diagnosis/Medical History (Please include all relevant information for the referral).

_____

_____

_____

6. Clinical Information

IS THIS WORK-RELATED OR ACCIDENT-RELATED INJURY OR ILLNESS: □ Yes □ No

Problem/reason for referral: _____

_____

REFERRED FOR CONSULT/RECOMMENDATION ONLY: □ Yes □ No If yes, list number of office visits: _____

CLINICAL INFORMATION: Please list treatment date and include if a diagnostic test, lab/pathology, radiology, or another procedure was performed. Also list the current CPT®/HCPCS code(s):

_____

_____

DATA ENCLOSED (Please check one): □ Lab Reports □ X-Rays/Radiology □ Narrative Reports □ Other (please list):

_____

STATUS □ Urgent □ Within _____ Days □ Routine

Primary Care Physician Signature	**Referral Date**

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