Primary care provider/IHS* referral form

Print or type in black ink. Please complete this form when you need to refer your patient for care. Please only refer them to UnitedHealthcare Community plan contracted care providers. 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 date of birth:
2. Primary care provider (PCP) information	
Member's primary care provider (PCP/IHS) name: IHS provider: ☐ Yes	PCP/IHS tax ID # /National Provider Identifier # (TIN/NPI):
PCP/IHS address (include city, state and ZIP code):	PCP/IHS phone/fax number:
3. Consulting/referring care provider information	
Consulting care provider name:	Consulting care provider TIN/NPI:
Consulting care provider address (including state and ZIP code):	
Consulting care provider phone/fax number:	
4. Other insurance coverage information (coordination of benefits)	
Does the patient have other insurance coverage? ☐ Yes ☐ No If yes, please indicate coverage: ☐ Medicare ☐ Motor vehicle accident ☐ Workers' compensation ☐ Commercial	
5. Member diagnosis/medical history (please include all relevant information for the referral)	
6. Clinical information	
Is this a work-related or accident-related injury or illness? ☐ Yes ☐ No Problem/reason for referral:	

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6. Clinical information (cont.)

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 ☐ Lab reports ☐ Narrative reports ☐ Other (please list)

Status: ☐ Urgent ☐ Within days ☐ Routine

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