Minnesota Restricted Recipient Program UnitedHealthcare referral form

Please complete this form in its entirety for the referral to be considered valid. Also, unless you specify a date range, the end date will default to 1 year from the submission date.

Recipient name	Private medical insurance number	Date of birth	Referral date
Primary care physician (PCP)	**NPI**	**Phone**	**Fax**
Referring to (first and last name)	**NPI**	**Specialty**	**Prescribing rights (Y/N)**
			Yes No
Clinic	**NPI**	**Phone**	**Fax**

Address

ICD-10 dignoses code(s)

Comments

PCP or delegate signature	Contact name	Start date	End date

Fax this form to 855-369-7560
Attn: UnitedHealthcare Restricted Recipient Program

Questions?
Call **888-413-0945.**

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United Healthcare Community Plan