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 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 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 (COB):

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 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 ❑ Lab reports ❑ Narrative reports ❑ Other (please list) _____

Status: ❑ Urgent ❑ Within days ❑ Routine

United Healthcare Community Plan