



Member Consent for Referring Out-of-Network Form

UnitedHealthcare maintains a nationwide network of care providers. You were given this consent form because your care provider would like to involve in your care a provider that is not in our network. This means you may have to pay:

- more out-of-pocket costs for the referred service, if you have out-of-network benefits, or
- the entire cost for the referred service, if you don't have out-of-network benefits.

We require your healthcare provider to tell you why he or she would like to use an out-of-network care provider. For this consent form to be effective, your healthcare provider must also summarize those reasons below.

We've also asked your healthcare provider to disclose any financial interest he or she has in the care provider he or she is referring to by checking the applicable box below.

- Your healthcare provider does have a financial interest in the out-of-network provider
- Your healthcare provider does not have a financial interest in out-of-network provider

If, upon seeing this information, you're okay with your doctor's choice to involve an out-of-network healthcare provider in your care, please give your consent below. This consent will only be valid for the service(s) your doctor refers on the date you sign this consent.

To be completed by your health care professional:

Health Care Professional Name	
Health Care Professional Tax ID #	
Member Name	
Member ID #	
Out-of-Network Provider Name	

To be completed by you or your legal guardian:

I am aware that my health care provider will involve in my care a health care provider that is not in UnitedHealthcare's network. I will be responsible for the entire cost of the service if I don't have out-of-network benefits. If my benefit plan includes out-of-network benefits, I may have increased costs.	
Signature of Member, Parent (if the member is under age 18) or Legal Guardian	
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Printed Name of Member, Parent (if the member is under age 18) or Legal Guardian	
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	Date: <hr/>