Meals/Medically Tailored Meals

CS Referral Form

Please Fax to UnitedHealthcare at 1-844-280-7080

Or send secure email to ca_cs_cm_referrals@uhc.com

Date: Choose Date

Diagnosis/ICD-10 Code or eligibility qualifiers: Click or tap here to enter text.

ID Number: Click or tap here to enter text.

Person Making the Referral: Click or tap here to enter text.

Organization Name: Click or tap here to enter text.

Case Manager/Care Coordinator Name: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Member Requesting CS: Click or tap here to enter text.

Name: Click or tap here to enter text.

Street Address: Click or tap here to enter text.

City/State/Zip: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Date of Birth: Choose Date

Secondary Contact Name/Relationship: Click or tap here to enter text.

Secondary Contact Phone/Email: Click or tap here to enter text.

Meal Plan Selection:

Number of Meals Requested: Click or tap here to enter text. Start Date: Choose date.

Member Primary Language: Click or tap here to enter text.

Check Medical Need: ☐Lower Sodium ☐Heart Friendly ☐Vegetarian

☐Diabetes Friendly ☐ Renal-Friendly ☐Gluten-Free ☐Pureed

Menu Comments/Special Delivery Instructions/Food Allergies:

Click or tap here to enter text.