United Healthcare

Recuperative Care / Medical Respite

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.

In addition:

Please submit signed Member consent form and documentation verifying need for Recuperative Care (medical respite) as preferred discharge plan. Upon approval, we will share assigned vender and their application/admission process.

CONSENT TO PARTICIPATE IN THE UNITED HEALTHCARE RECUPERATIVE CARE PROGRAM and CONSENT TO RELEASE PERSONAL HEALTH INFORMATION

EACH PARTICIPANT IS REQUIRED TO SIGN PRIOR TO PARTICIPATION

I have been offered the chance to take part in the UnitedHealthcare Recuperative Care Program through UnitedHealth Group, Inc., its subsidiaries and affiliates (United). I agree to take part in the UnitedHealthcare Recuperative Care program and I understand that this program is run with the participation of _____ (Agency). I understand that this program is available to United Medicaid members.

As a Medicaid Member, I understand that as a result of my participation, Agency will know that I am a Medicaid Member. I give my approval to United to tell Agency if I have coverage with United through the Medicaid Program. I understand and agree that any information I share with Agency, including personal health information (PHI) may be shared by Agency with United. And that United may follow up with me about services provided. I agree that the Agency and United may also make referrals to me and for me with other agencies for added services.

I release United and Agency, their agents and employees and agree to not hold them at fault for any and all liability, claims, damages, actions and causes of action whatsoever, for loss, damages or injury to persons or property, regardless of how they occurred and however caused. This includes but is not limited to all kinds and degrees or extent of negligence with which United and Agency and their agents or employees may be charged in connection, directly or indirectly with the UnitedHealthcare Recuperative Care Program. I understand that the Agency is solely responsible for providing me with any services. I also understand that should I choose to accept any services from an Agency, I should talk about the extent and any terms or fees associated with those services directly with the Agency, and United has no responsibility with respect to the agreement of the services to you by the Agency.

I understand that as part of my participation in UnitedHealthcare Recuperative Care, United may share my personal health information (PHI) with Agency and other social service agencies and that Agency may share my PHI with United for purposes of obtaining health, mental health and social service assistance.

I understand and agree that:

- this authorization is voluntary;
- my health information may contain information created by other people or facilities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, spreadable illness and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;

United Healthcare

- This document will expire one year from the date I sign it. I may revoke my approval at any time by notifying United in writing; but, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Type of Information to be disclosed:

☐ I agree to share of all my health information including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, spreadable illness and health care program information; **or**

☐ I agree to share only the following information:

_____

(Type of Information)

Purpose of Disclosure:

☐ My health information is being disclosed at my request or at the request of my personal representative; **or**

☐ My health information is being disclosed for the following purpose:

_____

(Explain Purpose)

****

_____ _____

Signature of Member Date

Member Printed Name: _____

Member ID: _____ (if applicable)

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Guardian or Representative:

_____ _____

Name Phone Number

_____ _____ ___ _____

Street Address City State Zip Code