Respite Services

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.

CS Specific Questions:

1. Is the Member compromised in the Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support? Choose an item.
2. Would the Member require institutional placement without their caregiver or temporary respite services? Choose an item.
3. How many days of respite is the care giver requesting? Choose an item.