Please fax completed form to: 844-882-6985

Or mail to: UnitedHealthcare Community Plan
1132 Bishop Street, Suite 400
Honolulu, HI 96813

Phone: Customer Service – 888-980-8728

Health coordination referral form

REFERRAL INFORMATION

Referred by ______________________ Phone number ______________ Fax number ______________

Relationship to member ______________ Email ______________

MEMBER INFORMATION

Medicaid ID number ______________ Member's name (Last, First, MI) ______________________ Date of birth ______________

Phone ______________ Address ______________________ Email ______________

Member's authorized representative/guardian/caregiver ______________________ Phone ______________

PROVIDER INFORMATION

PCP/specialist name ______________________ Phone number ______________ Fax number ______________

REASON FOR REFERRAL

Departmental/program referral – select as applicable

☐ Health coordination needs/medical needs	☐ Disability/ADRC/potential catastrophic	☐ Disease management
☐ Behavioral health	☐ Substance abuse	☐ Other, please specify
☐ Community Integration Services – CIS *Complete CIS referral form	☐ Pregnant member *Complete Obstetrics Risk Assessment or online care conductor and Notification of Pregnancy	

Identified criteria and needs – select as applicable

Health needs-based criteria		**Social risk factors/social determinants of health**
Select criteria	*Supporting diagnosis codes – list all*	*Select criteria*
☐ Needs assist with IADLs		☐ Z59.0 Homeless
☐ Needs assist with ADLs		☐ Z59.1 Inadequate housing
☐ Chronic medical condition(s)		☐ Z59.2 At risk of homelessness
☐ Behavioral health condition(s)		☐ Z59.4 Lack of adequate food/water
☐ Developmental disability		☐ Z59.5 Extreme poverty
☐ Substance use disorder		☐ Z59.6 Low income
☐ Pregnant – include EDC and any risk conditions		☐ Z55.0 Illiteracy/low literacy
☐ Other – please list:		☐ Other – please list:

INTERNAL USE ONLY

Date received ______________

Referred to: ☐ LTSS ☐ SHCN ☐ EHCN ☐ CIS ☐ Behavioral health ☐ Disease management ☐ Hāpai Mālama

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