

Maryland Uniform Consultation Referral Form

Date of Referral:	Carrier Information:
Patient Information:	Name: UnitedHealthcare
Name: (Last, First, MI)	Address: PO Box 5280, Kingston NY, 12402
Date of Birth: (MM/DD/YY) Phone: ()	Phone Number: ()
Member #:	Facsimile/Data #: (801) 994 - 1224
Site #:	

Primary or Requesting Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ()	Facsimile/Data Number: ()	

Consultant/Facility Provider:

Name: (Last, First, MI)	Specialty:	
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)
Address: (Street #, City, State, Zip)		
Phone Number: ()	Facsimile/Data Number: ()	

Referral Information:

Reason for Referral:		
Brief History, Diagnosis, and Test Results: <i>(Include ICD-9)</i>		
Services Desired: Provide Care as indicated:	Place of Service:	
<input type="checkbox"/> Initial Consultation Only:	<input type="checkbox"/> Office	
<input type="checkbox"/> Diagnostic Test: (specify) _____	<input type="checkbox"/> Outpatient Medical/Surgical Center*	
<input type="checkbox"/> Consultation With Specific Procedures: (specify) _____	<input type="checkbox"/> Radiology <input type="checkbox"/> Laboratory	
<input type="checkbox"/> Specific Treatment: _____	<input type="checkbox"/> Inpatient Hospital *	
<input type="checkbox"/> Global OB Care & Delivery	<input type="checkbox"/> Extended Care Facility *	
<input type="checkbox"/> Other: (Explain)	<input type="checkbox"/> Other: (Explain)	
	* (Specific Facility Must be Named.)	
Number of Visits: _____	Authorization #:	Referral is Valid Until: (Date) _____
If Blank, 1 Visit is Assumed.	(If Required)	(See Carrier Instructions)
Signature: (Individual Completing This Form)		Authorizing Signature: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan / carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Carrier/Plan Manual for Specific Instructions.