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: (*Include ICD-9*)

Services Desired: Provide Care as indicated:

- ☐ Initial Consultation Only:
- ☐ Diagnostic Test: (specify) _____
- ☐ Consultation With Specific Procedures: (specify) _____
  _____
- ☐ Specific Treatment: _____
- ☐ Global OB Care & Delivery
- ☐ Other: (Explain)

Place of Service:

- ☐ Office
- ☐ Outpatient Medical/Surgical Center*
- ☐ Radiology ☐ Laboratory
- ☐ Inpatient Hospital *
- ☐ Extended Care Facility *
- ☐ Other: (Explain)

* (Specific Facility Must be Named.)

Number of Visits: _____ .
If Blank, 1 Visit is Assumed.

Authorization #: _____
(If Required)

Referral is Valid Until: (Date) _____ .
(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.