

UnitedHealthcare Community Plan of New York specialist referral form

- Patient must be a covered member at the time of service
- Referrals must be generated for in-network specialists only
- Please use this form to submit referrals for CHP HARP, MCD members
- Retroactive referrals are not accepted
- Fax: 888-624-2748
- Mail: P.O. Box 31365, Salt Lake City, UT 84131-1362

Member name: (Last, First, MI):

Member ID #:

Phone:

Date of birth (MM/DD/YYYY):

Member address:

Referring primary care physician (PCP)

Name (Last, First, MI):

PCP tax ID #:

PCP National Provider Identifier (NPI) #:

Address: (Street #, City, State, ZIP code):

Phone:

Fax:

Specialist/rendering physician

Name (Last, First, MI):

Specialty:

Specialist tax ID #:

Specialist NPI #:

Address (Street #, City, State, ZIP code):

Phone:

Fax:

Referral information

Service requested: Routine referral
* 1-6 visits allowed

Standing referral. Requires qualifying diagnosis
* maximum 99 visits

Reason for referral:

Diagnosis with code (ICD-10). List at least 1, not more than 2:

(NOTE: maximum duration of 6 months)

Routine referral – 1 to 6 visits
Standing referral – 1 to 99 visits
Number of visits: _____
If blank, 1 visit is assumed

Routine service start

Date:

Routine service end

Date:

Standing referral start

Date:

Name and title of individual completing this form (only required if assigned PCP is NOT completing this form)

Signature of individual completing this form

Name of referring PCP

Today's date

Signature of referring PCP

Today's date