UnitedHealthcare Community Plan

UnitedHealthcare Community Plan Dual Complete Health Services Case Management Referral Form

Member Name:	Member ID:
Date of Birth:	Address:
City:	Zip:
Phone:	Cell:
PCP:	Phone:
Referred By:	Phone:
Language: English Spanish Other:	
MSR:	Date:
Ext/Phone:	

Check Appropriate CM Request:

ASTHAM CM	BEHAVIORAL HEALTH CM	DIABETES CM	PSYCHO/SOCIAL CM
CHF CM	PAIN CM	GENERAL CM	ER DIVERSION
TRANSPLANT/HEMOPHILIA CM	HIV CM	MOMS CM	MISSED APPOINTMENTS
BENEFIT EXPLANATION	OTHER:		

Reason for Case Management: _____

Goal: _____