Care Management Referral Form

Product: Connect/Connect + Medicare

Patient Information		
Member Name:	Date of Birth:	UCare ID#:
Mailing Address:	Phone:	
Language: ☐ English ☐ Burmese ☐ Hmong ☐ Karen ☐ Spanish ☐ Somali ☐ Russian ☐ Other:		Interpreter Needed: ☐ Yes ☐ No

Referral Source	
Name of person referring:	Phone:
Clinic/County/Organization:	Email/Fax:

Provider Information (if known)	
Primary Care Provider:	Phone/Fax:
Primary Care Clinic:	
Specialty Providers:	Phone/Fax:
Case Manager/County Worker:	Phone/Fax:
Power Of Attorney / Authorized Representative / Parent:	Phone:

Reason for Referral and Recommended Goals

*Attach any supporting documentation that maybe helpful in processing this referral for care management.

Fax to UCare at: 612-884-2033 **Email: CareSupportTeam@ucare.org**