UCare Individual and Family Plans Restricted Member Program
Medical Referral for UCare Restricted Member Enrollee

To ensure proper payment to the referral provider, the primary care physician must mail or fax this medical referral form immediately to the UCare Individual & Family Plans Restricted Member Program.

Section I: Primary Physician

Date:	Member Name:	DOB	UCare ID Number:
Primary Physician:		Provider I.D. Number:	
Street Address:			Phone Number:
City:	State:		Zip Code:

Section II: Referral Information

Referring to (First & Last Name):	Specialty:		I.D. #
Street Address:	Clinic Name:		I.D. #
City:	State:	Zip Code:	Phone Number:
Reason for Referral:			
ICD 9/10 Code			
☐ Refer for visit only ☐ Refer for visit and may prescribe medications if appropriate			
Start Date:	End Date:		
Provider Signature:	Print Provider Name		Date:

Fax this information to the UCare Individual & Family Plans Restricted Member fax line at 612-884-2316 as soon as possible.

If there are questions, please leave a message at 612-676-3397 or toll free at 877-447-4384. The Restricted Coordinator will return your call as soon as possible.