Minnesota Health Care Programs
Minnesota Restricted Recipient Program (MRRP)
Specialty Referral for UCare Restricted Recipient 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 Restricted Recipient Program. **All referrals must be received within 90 days of the date of service. Referrals received after 90 days from the date of service will not be processed.**

Date:	Recipient Name:	DOB	UCare ID #:

Section I: Primary Physician

Primary Physician:		NPI#
Clinic Street Address:		Phone Number:
City:	State:	Zip Code:

Section II: Referral Information

Referring to (First & Last Name):	Specialty:	NPI#
Street Address:	Clinic Name:	NPI#

City:	State:	Zip Code:	Phone Number:

Reason for Referral:

ICD10 Code

☐ Refer for visit only ☐ Refer for visit and may prescribe medication if appropriate

Start Date:	End Date:
Is this referral for a date of service in the past? ☐ Yes ☐ No	Date of Service (only required if service already occurred)

Primary Care Provider Signature:	Print Provider Name	Date:

For questions, please leave a detailed message on the UCare Restricted Recipient voicemail at **612-676-3397.**
The Care Coordinator will return your call as soon as possible.

Fax this information to the UCare Restricted Recipient fax at 612-884-2316 as soon as possible.