Restricted Recipient Program
Intake Form

Patient Information			
Patient Name	Date of Birth	UCare ID #	PMI#
Mailing Address		Phone Number	

Provider Information (if known)			
Primary Care Provider/Title	Primary Care Clinic	Phone	Fax

Reason for Referral

Please indicate reason for referral/chief concern:

Other helpful information on member:

Please attach any supporting documentation you believe would be helpful in processing this referral to the Restricted Recipient Program.

Referral Source		
Name	Phone	Fax
Clinic/Organization		Date

Please fax to UCare at: 612-884-2316