

NON-PARTICIPATING PROVIDER REFERRAL FORM

NEIGHBORHOOD HEALTH PARTNERSHIP

Fax completed form with pertinent clinical information to 800-731-2515

- Please be advised, failure to comply with Utilization Management certification protocol will result in non-payment of your claim.
- **Verification of benefits, eligibility, or authorization of a service is not a guarantee of payment. Payment remains subject to all of the terms and conditions of the member's benefit plan, including exclusions and limitations. If this member's coverage has pre-existing condition exclusion, payment will be subject to a pre-existing condition investigation at the time claims are filed.**
- All Specialist referrals must be made by a Primary Care Physician.

Appointment Date: ____ / ____ / ____

Today's Date: ____ / ____ / ____

Patient Information	Requesting Provider Information
Patient Name: _____	PCP Name: _____
ID Number: _____	Provider ID: _____
Patient DOB: ____ / ____ / ____	Phone: _____ Fax: _____
Diagnosis Code: _____	Contact Name: _____
Referral Information	
Referral Provider: _____	Reason for this out of network request: _____
Specialty: _____	_____
Phone: _____ Fax: _____	_____
Is this provider a UnitedHealthcare Provider?	_____
<input type="checkbox"/> Yes	_____
<input type="checkbox"/> No	_____
If yes, UnitedHealthcare Provider ID: _____	
Have participating providers seen this member for this condition?	CPT Code(s): _____
<input type="checkbox"/> Yes	_____
<input type="checkbox"/> No	_____
List provider(s): _____	Diagnosis Code(s): _____
_____	_____

