

Service requests may be entered directly by registered providers at uhcmilitarywest.com

Fax referral to: UnitedHealthcare Military & Veterans at:

877-890-9309 Routine

(Check one) 877-890-8203 Urgent (*Care needed within 72 hours*)

877-578-2738 Inpatient

Anticipated Date of Service: __/__/_____

Admission Type:

ER

Direct Admit

Elective

Service Type: (Check one) <input type="checkbox"/> Specialty Referral	<input type="checkbox"/> Inpatient (Acute, SNF, or Rehab)
<input type="checkbox"/> Outpatient (Medical/Surgical/Home Health)	<input type="checkbox"/> DME

Beneficiary Information (Completion of **ALL** fields is **REQUIRED**)

Last Name:	First Name:	M.I.:	Gender:	DOB: (mm/dd/yyyy)
Address: Street		Apt. No.:	City:	State: ZIP Code:
Contact Phone #:	<input type="checkbox"/> Sponsor SSN <input type="checkbox"/> Benefits Number (found on <i>back</i> of ID card):			

Diagnostic Information (REQUIRED FOR ALL REQUESTS: Diagnosis codes and Episode of Care Name and/or CPT Codes)

Diagnoses (ICD Code(s)):	Diagnosis Description:															
Episode of Care:	Clinical Information/Description of Requested Service (Include attachments as needed):															
<i>(ATTN: Use exact name from EOC Reference Table available at www.uhcmilitarywest.com)</i>																
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">CPT 4 Code(s) / HCPCS Code(s):</th> <th style="width: 12.5%;"># of Units:</th> <th style="width: 25%;">CPT 4 Code(s) / HCPCS Code(s):</th> <th style="width: 12.5%;"># of Units:</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		CPT 4 Code(s) / HCPCS Code(s):	# of Units:	CPT 4 Code(s) / HCPCS Code(s):	# of Units:											
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Requesting Provider Information (Do not use group name) (Completion of **ALL** fields is **REQUIRED**)

Last Name:	First Name:	NPI #:
Address: Street		Suite: City: State: ZIP Code:
Office Phone #:		Office Fax #:
Contact Name:		Contact Department:

Servicing Provider (Check One) Physician Facility Agency Vendor

Last Name or Entity Name (Required):	First Name (Required for Physician):	<input type="checkbox"/> NPI <input type="checkbox"/> TIN
Address (Required): Street		Suite: City: State: ZIP Code:
Specialty (Required):	Office Phone #:	Office Fax #:

Servicing Facility (Required if applicable)

(Check One) Acute Inpatient Outpatient Skilled Nursing Observation Rehabilitation

Facility Name:	<input type="checkbox"/> NPI <input type="checkbox"/> TIN	
Address: Street		Suite: City: State: ZIP Code:
Office Phone:		Office Fax: