UnitedHealthcare
MILITARY & VETERANS

# Case Management Referral Form

| Name of Referral Source: | Referral Source Phone: | Date: (mm/dd/yyyy) ____ / ____ / ______ |
|---|---|---|
| Referring From: | | MTF-DMIS Number: |

Specialized Case Management:
☐ Warrior Advocacy ☐ Children with Special Health Care Needs ☐ ECHO (see page 2 for referral form)

Complex Case Management:
☐ Chronic Kidney Disease ☐ Healthy Pregnancy ☐ NICU ☐ Cancer Program ☐ Cancer Clinical Trials
☐ Congenital Heart ☐ Transplant

| General Case Management: | Community Case Management: |
|---|---|
| ☐ Behavioral Health ☐ Medical Surgical | ☐ Behavioral Health ☐ Medical Surgical |

**Beneficiary Information**

| Full Name: Last | First | M.I. | Beneficiary ID: (SSN w/dependent code) |
|---|---|---|---|
| Beneficiary Date of Birth: (mm/dd/yyyy) ____ / ____ / ______ | | | Phone Number: |

| Address: Street | Apt. No. | City | State | ZIP Code |
|---|---|---|---|---|

Diagnosis–Primary/Secondary:

| Physician Name: Last | First | Physician Phone Number: |
|---|---|---|

**Additional comments or attach clinical documentation/case summary**

Description:

## Fax referral to: UnitedHealthcare Military & Veterans at:
## 877-890-9276 Urgent
## 877-891-2093 Routine

For more information, please call our customer service number toll-free at **1-877-988-9378** from 7 a.m. to 7 p.m. local time, Monday through Friday.

Total Pages Faxed: ______

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**TRICARE West Region Customer Service: 1-877-988-9378 (WEST) ▪ www.uhcmilitarywest.com**

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MILITARY & VETERANS

# Extended Care Health Option (ECHO) Referral Form

**To refer a beneficiary for registration in the ECHO program, complete this form and include any additional information that may assist in providing services to the beneficiary.**

| **Beneficiary Information** | | | |
|---|---|---|---|
| Beneficiary Name: Last | First | M.I. | Beneficiary Date of Birth: (mm/dd/yyyy): ____ / ____ / ______ |
| Beneficiary DoD ID/Benefits # or Sponsor's SSN: | | | |
| Sponsor Name and Relationship: | | | |
| Home Address: Street | Apt. No. | City | State / ZIP Code |
| Telephone Number: | Other Telephone Number: | | |

| **Referral Source Information** | |
|---|---|
| Name of Person Completing Form: | Phone: |
| Beneficiary's Primary Physician: | |
| Physician Phone: | Fax: |

| **Specialist(s) Involved in Care** | |
|---|---|
| Specialist Name (1): | Specialty: |
| Phone: | Fax: |
| Specialist Name (2): | Specialty: |
| Phone: | Fax: |

| **Diagnosis (es)** | |
|---|---|
| Reason for Referral: | |
| **Has the beneficiary or primary caregiver been informed that this referral was being submitted?** | ☐ Yes ☐ No |
| ☐ Autism Demonstration Program<br>☐ Durable Equipment<br>☐ ECHO Respite | ☐ ABA Therapy<br>☐ ECHO Home Health Care<br>☐ Other (Describe) ______________________ |

## Fax referral to: UnitedHealthcare Military & Veterans ECHO Program at:
## 877-890-9276 Urgent
## 877-891-2093 Routine

For more information, please call our customer service number toll-free at **1-877-988-9378** from 7 a.m. to 7 p.m. local time, Monday through Friday.

Total Pages Faxed: ______

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