UMR Case Management Referral Form

Return via secure mail to:
CMC contact information here

Name and title of person making referral:	**Date:**	
	Phone:	
	Fax:	

Program name: Case Management
Please complete the following fields:

Diagnosis:

Providers (doctor or facility):

Treatment course (if known):

Participant information:			
Last name:	**First name:**	**Date of birth:**	
Member ID:	**Gender:** Male ☐ Female ☐		
Customer name:	**Group number:**		
Street address:	**City:**		
State: CO	**ZIP:**	**Phone:**	
Best time to call: Morning ☐	Afternoon ☐	Evening ☐	
Other information you would like us to know:			

UMR℠
A UnitedHealthcare Company