Health Plan of Nevada
A UnitedHealthcare Company

Health Plan Referral Form

Note: Referral Form should be sent directly to the specialist you are referring to

Date of Request: _____

Insurance Information

Health Plan of Nevada: Commercial ☐ Medicaid ☐

Other Insurance(s): _____

Member Information

Member Name: _____ Member ID Number: _____

Member Date of Birth: _____ Member Phone Number: _____

Member Address: _____

Referring Provider Information

Name: _____ Phone Number: _____

Contact Person (Name, Phone, and Fax): _____

_____

Referral Information

Referring To (list provider or group name): _____

Specialty/Treatment Requested: _____

Reason for referral (please include diagnosis and any other applicable information):

_____

_____

_____

*All sections of this form must be completed.

**Southern Nevada – please refer to Southern Nevada Referral Guidelines here for necessary testing and/or labs - https://healthplanofnevada.com/Provider/Provider-Summary-Guide

This referral is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage, Certificate of Coverage, or Self Insured Employer's Plan Documents.

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