



For emergencies, call 911 or your local police for a welfare check

Date of request: _____

Person submitting request: _____

Organization/program/office: _____

Phone: _____ Email: _____

Urgent contact needed (within one business day)

Patient information:

Patient aware of request

Patient name: _____

DOB: _____ Member/Medicare ID: _____

Phone one: _____ Phone two: _____

Patient address: _____ ZIP code: _____

Patient's home

Family's home

Group home/ALF/LTC: _____

***If patient is currently in acute setting, planned date of discharge: _____

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POA/authorized rep./alternative contact: _____

Phone: _____ Relationship to patient: _____

Currently, who is patient's decision-maker? _____

PCP name: _____ PCP phone: _____

Primary reason for request: _____

Social:

- Basic needs (food, shelter, clothing)
- Behavioral health support
- Financial needs (AHCCCS, ALTCS)
- Lack of support system
- Transportation

Medical:

- Chronic disease management
- Disease education
- Fall assessment
- Medication management

General:

- Advanced directives
- Coordination of care
- Custodial care
- Palliative care
- Advanced wound care

Additional information regarding patient needs/concerns:

Pertinent medical information (hospitalizations, PMH, diagnoses, etc.):



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Provider form for patient programs

Email: servicecoordination@optum.com

Fax: 1-888-405-2734

Questions? Please call **1-623-293-9775**, TTY **711**.

**REMINDER: Send in secured format
as document contains confidential PHI.**