

INSTRUCTIONS <ul style="list-style-type: none"> • Please complete the below form. • Required fields are marked with an *. • Return the form through one of the methods listed below. 	
SUBMITTING REFERRALS <ul style="list-style-type: none"> • Through the OptumCare Portal, found at www.optumcare.com. • Fax the completed form to: 888-992-2809 • If you have your own secure email system, please submit the form to LCD_UM@optum.com. If you do not have your own secure email system, please contact our service center at 1-877-370-2845. We will ask for your email address and will send a secure email for the form to be sent to our office. 	
SECTION 1: Member Information	
*Member Name	
*Member ID Number	*Date of Birth
*Address (City, State, ZIP Code)	
*Telephone Number	Extension
SECTION 2: Primary Care Provider (PCP) Information	
*Primary Care Provider Name	
PCP Tax Identification Number (TIN)	PCP National Provider Identifier (NPI)
Address (City, State, ZIP Code)	
*Telephone Number	Extension
*Fax Number	*Contact Name
In-Network Provider Specialty (if other than PCP)	
SECTION 3: Referred To Specialist Information	
*Specialist Name	
Specialist Tax Identification Number (TIN)	Specialist National Provider Number (NPI)
*Address (City, State, ZIP Code)	
*Telephone Number	Extension
*Fax Number	In-Network Provider Specialty
SECTION 5: Referral for Evaluation and Treatment Information	
Start Date XX/XX/20XX (Initial referrals are valid for six (6) months after start date)	Referring Diagnosis (Enter a general diagnosis that explains why the patient needs to see the specialist.)
Type of Request	
<input type="checkbox"/> Initial Referral Request <input type="checkbox"/> Subsequent Referral Request	