



INSTRUCTIONS

- Please complete the below form.
- Required fields are marked with an *.
- Return the form through one of the methods listed below.

SUBMITTING REFERRALS

- Through the OptumCare Portal, found at www.optumcare.com.
- Fax the completed form to: **844-206-5736**
- If you have your own secure email system, please submit the form to colorado.medmgmt@optum.com
- If you do not have your own secure email system, please contact us at 888-685-8491. We will ask for your mail 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

InitialReferralRequest

Subsequent Referral Request