OPTUM®

**Provider form for patient programs**
Email: OMWcmreferral@optumcare.com

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

Date of request: _____

Person submitting request: _____

Organization/program/office: _____

Phone: _____ Email: _____

☐ Urgent member contact needed

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**Patient information:** ☐ **Patient aware of request**

Patient name: _____

DOB: _____ Member/Medicare ID: _____

Phone: _____ 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:** _____

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Primary reason for request (please be specific): _____

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**Social:**
- ☐ Basic needs (food, shelter, clothing)
- ☐ Financial needs (AHCCCS, ALTCS)
- ☐ Lack of support system
- ☐ Transportation
- ☐ Advanced directives

**Medical:**
- ☐ Complex case management
- ☐ Chronic disease management
- ☐ Medication management

**General:**
- ☐ Transitional care
- ☐ Coordination of care
- ☐ Palliative care

**Additional information regarding patient needs/concerns:**

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



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