Provider referral form for patient programs

Email: umutah@optum.com

Fax: 1-844-461-5749

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

Date of request: ______________________________

Person submitting request: ______________________________

Organization/program/office: ______________________________

Phone: ______________________ Email: ______________________

PCP name: ______________________ PCP phone: ______________________

☐ 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**: ____________

POA/authorized rep/alternative contact: ______________________________

Phone: ______________________ Relationship to patient: ______________________

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

Programs available (choose one or more)

☐ Device-enabled condition management (check which box applies below)

☐ CHF ☐ COPD ☐ Diabetes

☐ High-risk care management

☐ Medical behavioral integration

☐ Short term case management

☐ Social work

☐ Palliative care

☐ Woundtech

☐ Kidney resource specialist: (check which box applies below)

☐ Chronic kidney disease

☐ End stage renal disease

Primary reason for request: ______________________________

Additional information regarding patient needs/concerns:

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

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