OptumCare Primary Care Provider (PCP) Referral Form

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: **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 Identifer (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 ☐ Initial Referral Request ☐ Subsequent Referral Request	