OPTUM Care® | Network of Connecticut

Date Received by OCNCT

Referral Authorization Request Form

OptumCare® Network of Connecticut

☐ **PATIENT REQUEST** ☐ Routine (14 Calendar Days) ☐ Medically Urgent (72 Hours) ☐ Time Sensitive (72 Hours with Notification to UM)

Please type or print clearly in blue or black ink. **Submitted by:** ____________ **# of Pages** ______

A. Member Information — *All Fields Required*

Patient Name	Member ID	Health Plan	DOB
Patient Address			Phone #

B. Primary Care Physician Information — *All Fields Required*

PCP	Phone #

C. Requesting Provider Information — *All Fields Required*

Requesting Physician	Phone #

D. Requested Provider Information — *All Fields Required*

Referred To	Specialty	Phone #
Place of Service		Fax #

E. Diagnosis and Service Requested Information — *All Fields Required*

ICD-10 Code(s)	Diagnosis Description
CPT Code(s)	Service Description

Date of Service or Admission	☐ Second Opinion ☐ Accident-related injury? Date of injury:____________ *If work-related injury, refer to worker's comp provider. Do not submit to NAMM California.*	# of Visits or Tx

F. Clinical Information

Reason for Referral/Clinical Notes *(Please attach chart notes to document medical necessity.)*
Please list.

G. Physician Signature — *Form will be returned without signature.*

Requesting Physician's Signature *(Referral incomplete without MD or DO signature.)*	Date

Please note: ***This form is not a guarantee of payment.*** Charges for noncovered services or services rendered to ineligible patients are the responsibility of the patient.

For questions, call UM at 888-556-7048. **Fax referral requests to 855-268-2904.**

H. Status (For internal use only.)

Criteria Used: ☐ MCG ☐ Health Plan ☐ CMS ☐ Internally Developed

☐ Pend ☐ Approved ☐ Denied ☐ Duplicate **Not Processed; Returned**

Date ____________ Initials ____________ Ref # ____________

☐ Member not effective
☐ Member could not be identified
☐ Carve-Out/HP Responsible

Prov Notified: ☐ Phone Date/Time: Initials: ☐ System Fax ☐ Manual Fax ☐ Courier ☐ Overnight Fax

(Urgent/Exp) Mbr Notified: ☐ Phone Date/Time: Initials: ☐ Letter Date/Time: Initials:

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Updated: 02/23/2018
Created: 09/07/2016