Optum Care Network
904 7th Ave 2nd Floor Admin Office
Seattle WA 98104
optum.com

CARE MANAGEMENT REFERRAL FORM

Date: Click or tap to enter a date.

MEMBER INFORMATION

Member Name:	Member DOB:	Member Health Plan ID:	Member Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

If primary contact is <u>not</u> the member, provide the following:

Contact Name:	Relationship to Member:	Contact Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

REFERRED BY

Name:	Title:	Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

LINE OF BUSINESS

Choose an item.

If Other, please specify:
Click or tap here to enter text.

PRIMARY CARE PROVIDER INFORMATION (OPTIONAL)

PCP Name:	PCP Office Address:	PCP Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

DIAGNOSIS AND REASON FOR CARE MANAGEMENT REFERRAL

Diagnosis(s):	Reason or Need for Assistance:
Click or tap here to enter text.	Click or tap here to enter text.

PROJECTED OUTCOME FROM CARE MANAGEMENT (OPTIONAL)

Reason or Need for Assistance:
Click or tap here to enter text.

INSTRUCTIONS FOR REFERRAL SUBMISSION:

Complete this referral form and fax to

253-356 5778