OPTUMHealth™

Use this form to notify OptumHealth Care Solutions of your transplant referral. Please fax to your Managed Transplant Program Case Manager at Fax: 1-855-250-2169 or email to mtptrans@optumhealth.com

SECTION 1 – REFERRAL INFORMATION

Date: Referring Case Manager: Telephone #:

SECTION 2 - BENEFIT INFORMATION (OPTIONAL)

Deductible: $ Copay: $ Out of Pocket Max: $ Lifetime Max: $

SECTION 3 – PATIENT INFORMATION

Paient Name: _____ Group Name: _____

Patient Relationship to Insured: _____ Group #: _____

Policy Holder: _____ Subscriber ID: _____

Street Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____

Member Enrollment Date: _____ Coverage Effective Through: _____

Employer Effective Date: _____ Employment Status: _____ ☐ Cobra ☐ Disabled

Medicare Effective Date: _____ Employer: _____ Employer Phone #: _____

Medicaid Effective Date: Eligibility Screen Attached: ☐ Yes ☐ No

SECTION 3 - CLAIMS INFORMATION

Claims Mailing Contact: _____ Phone #: _____ Fax #: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Claims Status Contact: Phone #: Fax #:

SECTION 4 - MEDICAL INFORMATION

Primary Diagnosis: _____ Related Diagnosis: _____

Medical History: _____

Evaluation Date: _____ List Date: _____ Transplant Type: _____

Facility: _____ Admit Date: _____ Dialysis Start Date: _____

Current Treatment Facility: _____ Referring Physician: _____

Last DOS: Contact Person: Telephone #:

SECTION 5 - OTHER INFORMATION