Optum | Mountain West
(AZ, CO, ID, NM, OR, UT, WA)

Provider form for patient programs
Securely email fully completed form to:
cmintake@optum.com

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

Date of request: _____

Person submitting request: _____

Organization/program/office: _____

Phone: _____ Email: _____

☐ 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? _____

PCP name: _____ PCP phone: _____

Primary reason for request: _____

Social:

- ☐ Basic needs (food, shelter, clothing)
- ☐ Behavioral health support
- ☐ Financial needs (AHCCCS, ALTCS)
- ☐ Lack of support system
- ☐ Transportation

Medical:

- ☐ Complex case mgmt.
- ☐ Disease mgmt. (COPD, CHF, DM)
- ☐ Medication management
- ☐ Renal disease

General:

- ☐ Advanced directives
- ☐ Coordination of care
- ☐ Palliative care
- ☐ Advanced wound care

REQUIRED information regarding needs/reason for referral:

Pertinent medical information (Hospitalizations, PMH, diagnoses, etc.):