OPTUM®

REFERRAL FORM

Physician NPI: _____

Physician License #: _____

AMERIHEALTH CARITAS OF LOUISIANA

TO:	REFERRAL TEAM	Physician Name:	
FAX:	866-252-4293	Credentials:	Specialty:
PHONE:	800-999-2106	Practice Address:	
DATE:	EDC:	City / State / Zip:	
REFERRAL FROM:	❑ MD Office ❑ Insurance Company	Office Contact:	
INSURANCE PROVIDER:		Fax:	Phone:

Patient Location *(at time of referral)*: ❑Home ❑Hospital ❑Other: Preferred Language: ❑English ❑Other: _____

PATIENT INFO: Name: _____ DOB: _____ State of Residence: _____

Phone (H): _____ Phone (C): _____

TO GENERATE OPTUM PHYSICIAN PLAN OF TREATMENT: (Check One)

❑ UTILIZE OPTUM PROTOCOL / PREFERENCES ON FILE **OR** ❑ CALL FOR PATIENT-SPECIFIC ORDERS AT: _____

SERVICE REQUESTED: (CHECK ALL THAT APPLY)

PRETERM LABOR MANAGEMENT	❑ 30-Day Program ❑ 7-Day Program	
NAUSEA & VOMITING MANAGEMENT	❑ ONDANSETRON (Zofran®) ❑ Continuous SQ ❑ Continuous PICC	❑ ONDANSETRON (Zofran®) W/HYDRATION ❑ Continuous SQ ❑ Continuous PICC HYDRATION ORDERS: ❑ Peripheral IV ❑ PICC Line ❑ Per Optum protocol (D5LR 3L/day x 2 days and PRN) ❑ Contact MD for patient-specific orders
	❑ METOCLOPRAMIDE (Reglan®) ❑ Continuous SQ ❑ Continuous PICC	❑ METOCLOPRAMIDE (Reglan®) W/HYDRATION ❑ Continuous SQ ❑ Continuous PICC HYDRATION ORDERS: ❑ Peripheral IV ❑ PICC Line ❑ Per Optum protocol (D5LR 3L/day x 2 days and PRN) ❑ Contact MD for patient-specific orders
Coagulation Disorders	❑ Heparin Subcutaneous Infusion Pump	
PREECLAMPSIA MANAGEMENT	❑ At Risk for Preeclampsia ❑ Preeclampsia with 14-day Follow-up	
DIABETES MANAGEMENT	❑ Non-Insulin ❑ Insulin Injections ❑ Insulin Pump	
RECURRENT PRETERM BIRTH MANAGEMENT PROGRAM	❑ Makena home administration and care management service by Optum. MD office prescribing medication directly through specialty pharmacy. Medication arrangements to be handled by MDO. **Please enter pharmacy name and contact phone/fax information if known.** _____ Phone: _____ Fax: _____	
	❑ Other: _____ [PHYSICIAN/PATIENT TO PROCURE MEDICATION] **Please enter pharmacy name and contact phone/fax information if known.** _____ Phone: _____ Fax: _____	
OTHER SERVICE REQUEST		

ATTACH THE FOLLOWING DOCUMENTS WITH YOUR REFERRAL SUBMISSION:

❑ FACE Sheet/Demographic Sheet ❑ Prenatal Records / Progress Notes / MFM Consultation Report ❑ Front and Back of Insurance Card

Has request for service been discussed with patient? ❑ Yes ❑ No Does Optum have permission to contact the patient? ❑ Yes ❑ No

INSURANCE AUTHORIZATION:

AUTHORIZATION #: _____ DATES OF AUTHORIZATION: FROM: _____ TO: _____

CASE MANAGER: _____ *(NAME)* PHONE: _____ FAX #: _____

ADDITIONAL COMMENTS:

Optum will respond via fax to acknowledge receipt, request any missing documentation, and provide a Physician Plan of Treatment (PPOT) form for signature.

Thank You For Your Referral !