CONFIDENTIAL

NOTIFICATION FORM
CLIENT

Use this form to notify Optum of your intent to access its participating health care provider agreement for evaluation and/or specialized services. Please fax to Optum at (877) 897-5338 or email to cmc_client_services@optum.com.

Complete Sections 1–4 for the following referrals:	Complete sections 1-4 and the corresponding section for the following referrals:
☐ Transplant Network ☐ Transplant Access Program	☐ Congenital Heart Disease (section 5) ☐ Cancer Resource Services (section 6) ☐ Bariatric Resource Services (section 7) ☐ Kidney Resource Services (section 8) ☐ Spine and Joint Solutions (section 9) ☐ Ventricular Assist Device Program (section 10)

SELECT THE LINE OF BUSINESS: COMMERCIAL ☐ / MEDICAID ☐ / MEDICARE ☐

Is this an Extra Contractual or non-OptumHealth contracted medical center/program referral? ☐ Yes ☐ No

SECTION 1 - MEDICAL CENTER INFORMATION

Medical Center: Program Type:

SECTION 2 - CLIENT INFORMATION

Client: ______ Distributor: ______

Stop Loss Carrier: ______

Stop Loss Carrier Contact: ______ Stop Loss Carrier Contact Phone #: ______

Client Case Manager: ______ Phone #: ______ Fax #: ______

Street Address: ______ E-mail Address: ______

City: State: Zip Code:

SECTION 3 - CLAIMS INFORMATION

Claims Mailing Contact: ______ Phone #: ______ Fax #: ______

Claims Mailing Address: ______ City, State & Zip: ______

Claims Status Contact: Phone #: Fax #:

SECTION 4 - PATIENT INFORMATION (Patient Name and ID# must be exactly as it appears on health care ID card)

Name: ______ ID #: ______ ☐ M ☐ F DOB: ______ Phone #: ______

Street Address: ______ City, State & Zip: ______

Diagnosis: ______ ICD9/10 Code: ______

Has the patient been evaluated, received services or had surgery at this center? ☐ Yes ☐ No ☐ Eval/Svcs/Surgery not scheduled

☐ Eval/Svcs/Surgery rendered on: ______ ☐ Eval/Svcs/Surgery scheduled for: ______

Employer/Group: ______

Patient Coverage Effective Date: ______ Eligibility Verification Phone #: ______

Other Coverage (if applicable): ______ ☐ Primary ☐ Secondary

☐ Medicare ☐ Medicaid Effective Date (if applicable): ______

Accessing Phase V? (Optional post-transplant phase of the Optum contract) ☐ Yes ☐ No

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SECTION 5 - FOR IN-UTERO OR NEWBORN CHD REFERRALS, PLEASE COMPLETE THE FOLLOWING:

Mother's Full Name: ______ ID #: ______ Primary Insured? ☐Yes ☐ No

Father's Full Name: ______ ID #: ______ Primary Insured? ☐Yes ☐ No

SECTION 6 – IF CANCER RESOURCE SERVICES, PLEASE COMPLETE THE FOLLOWING:

CRS case remains in effect until: Is this a Renewal? ☐ Yes ☐ No

SECTION 7 – IF BARIATRIC RESOURCE SERVICES, PLEASE COMPLETE THE FOLLOWING:

Medical Center Tax ID: ______ Group # as noted on member ID card: ______

Patient Height (CM): Patient Weight (Kg):

SECTION 8 - IF KIDNEY RESOURCE SERVICES, PLEASE COMPLETE THE FOLLOWING:

CMS ID: ______ Medicare Certified? ☐ Yes ☐ No

Patient Height (CM): ______ Patient Weight (Kg): ______

EPO Dosage (Units): ______ Frequency Per Week: ______ Route: ☐ IV ☐ SQ

OON Deductible: ______ OON Out of Pocket: ______ OON Co-pays: ______

Does the patient have a co-payment, co-insurance or deductible that, combined, is less than $10,000 per calendar year? ☐ Yes ☐ No

SECTION 9 – IF SPINE AND JOINT SOLUTIONS, PLEASE ADD INFORMATION HERE

Case Effective Date ______

Surgical Indication Date ______

Surgery Date ______

SECTION 10 – IF VENTRICULAR ASSIST DEVICE PROGRAM, PLEASE COMPLETE THE FOLLOWING:

Select Program Type:
- ☐ Bridge to Transplant
- ☐ Destination Therapy
- ☐ VAD Destination Unknown

Accessing contract for VAD Equipment and Supplies? ☐ Yes ☐ No

If "Yes" above, fill in section to the right.

Only fill in this section if accessing a VAD Equipment and Supplies contract.

Vendor (choose one): ☐ Alere (Heartware) or ☐ Continuum (HeartMate II)

Equipment type:
- ☐ All Inclusive Rental
- ☐ Replacement Equipment
- ☐ Wound Care

SECTION 11 - COMMENTS

______

NOTE: INFORMATION IN THE SHADED AREA PERTAINS ONLY TO TRANSPLANT PATIENTS.
Medical Center is responsible for verifying continued eligibility and benefits for health services and for obtaining prior authorization for certain health services and referrals, as defined by the client (including inpatient/outpatient services, rehabilitation services and HHC/DME). ***Medical Center is responsible for providing client, upon the member's acceptance or listing with UNOS, with documentation that shows member meets the medical center's transplant selection criteria.***

Client case manager is responsible for notifying medical center of their request that clinical correspondence be copied to the case manager, primary physician and/or referring physician. Client case manager is responsible for the coordination of patient care.

The health services described on this Notification Form falls within the terms of the participation agreement between Optum and Medical Center named above. Client, through its agreement with Optum, has access to the rates described in that participation agreement.

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