



Ancillary Workers' Comp Referral Form

Our Ancillary Referral Form is a quick and easy way to submit a referral for ancillary products and services. In the event of questions, immediate service needs, or should you wish to speak with one of our representatives, please call us at 1-833-486-7886, option 2. Otherwise, we will contact you within 24 hours of receipt to obtain any additional claim details to process this referral.

Fields marked with **red *** are required.

Claim Type New Claim Date needed
Existing Claim

Referral Source

Your Name* Email Address*
Company Name Phone Number*
Relationship to Claimant: Claims Professional Case Manager Other - specify:

Claimant Information

Claimant Name* Date of Birth*
Phone number* Street address
City State Zip
Claimant height Claimant weight Claimant language
Check if deliver to address *is different* than address above. If different, provide deliver to address below:
Street address City State Zip

Claim Information

Adjuster Name Adjuster Email
Claim Number* Employer Name
Insurance Carrier/TPA* Date of Injury*
State of Injury/Jurisdiction*
Physician Name* Physician License Number
Physician Phone Number* Physician Address
City State Zip
Diagnosis Code

Services Needed

Medical Equipment and Supplies Tens Home Modifications
Catastrophic Care Home Health Care Vehicle Modifications
Prosthetics Diagnostic Services Other:
Orthotics

Comments or Other Services

Step 1: Save this file with a new name

Step 2: Complete this form and click the "Submit by email" button. All required fields must be completed.

If you are unable to send via the Submit button, please save this file and send as an attachment with any additional documentation in support of the request such as prescriptions, doctors orders, evaluations, etc. via email to Optum at OptumWC.Ancillary@optum.com

or

Save this file and fax the completed form and attachments to **800-774-4111**

Need to complete another referral? Clear the form and start over. Be sure to save file with a new name.