Optum

Clinical services request form

Point and click to fill in the fields or use the Tab key to move to the next field. **All fields are mandatory. Email submission is preferred.** To send via email: sign the form by typing your name on the signature line and send as an attachment to the email address listed below. Or, print, sign and fax this form to the number listed below. Questions? Call 1-877-275-7674 ext. 8612.

Form submission

Email (multiple emails may be required if files are too large):
OptumWC.ClinicalServices@optum.com

Fax (if less than 50 pages):
1-800-514-3371

Or mail (if more than 50 pages):
Optum Clinical Department
175 Kelsey Lane, Tampa, FL 33619

Service Requested (please check all services desired) Service descriptions on pages 2-3

☐ **Medication Review**
- ☐ Do Send Clinical Intervention Verification Letter(s)
- ☐ Do **NOT** Send Clinical Intervention Verification Letter(s)

☐ **Medication Review with Peer-to-Peer Outreach**
- ☐ Do Send Clinical Intervention Verification Letter(s)
- ☐ Do **NOT** Send Clinical Intervention Verification Letter(s)

☐ **Nurse Progress Monitoring***
**Not a stand-alone service; only offered in conjunction with Medication Review with Peer-to-Peer Outreach*

☐ **Drug Utilization Evaluation (DUE)**

Drug Testing Services
- ☐ Drug Testing
- ☐ One-Time Test Result Review

Requester information

Requester name: _____ Payer: _____ Branch office location: _____

Billing address: _____ State: _____ Zip: _____

City: _____

Requester title (i.e., Adjuster, Case Manager, etc.): _____

Requester phone number: _____ Requester fax number: _____

Requester email address: _____

If the completed review cannot be emailed or faxed, to what address should it be mailed?

Requester mailing address: _____

City: _____ State: _____ Zip: _____

Case manager information (if applicable)

Case manager name: _____ Email address: _____

Injured person information

Injured person name: _____ Date of birth: _____ Date of injury/loss: _____

Claim/policy number: _____ State of jurisdiction: _____

Employer/Insurer: _____ Employer/Insurer address (city, state): _____

Description of injury and all claim-related diagnoses:

Specific medications approved by UR or court ordered (mark N/A if not applicable): _____

Specific medications to be excluded from review (mark N/A if not applicable): _____

Reason for request: _____

Authorization

I authorize this request for Clinical Services for the injured person listed above.

Requester Signature: _____ Date: _____

Sales representative information

Name: _____ Email address: _____ Phone number: _____