Referring a patient

UC DAVIS HEALTH

Thank you for choosing UC Davis Health and for referring your patient to us. We appreciate the opportunity to partner with you in your patient's care.

To begin the referral process, please complete our **referral intake form** online and **fax it to our Physician Referral Center at 916-703-6048.**

Please allow up to 48 hours for processing of your referral. Please be advised incomplete information or need for clarification may delay the process.

If this is an URGENT request, please call the Physician Referral Center at 800-482-3284 option #3.

Checklist for non-urgent referrals:

Prior to submitting a referral, please complete the following:

- Obtain insurance plan authorization
- Confirm patient name and name on insurance card(s)
- Obtain copy of most up-to-date insurance card(s)

Please submit the following with your referral request:

- ☐ Completed UC Davis referral intake form
- ☐ Recent/relevant typed clinical notes/test results (health history, physical, MRI/CT/X-ray results, etc.)
- ☐ Proof of insurance
- ☐ Authorization information with CPT code details and approved visits

Please fax all of documents to the Physician Referral Center at 916-703-6048.

Referral intake form

UC DAVIS HEALTH

Please fax this completed form and checklist items to **916-703-6048.** Number of pages: _____

Are you the patient's PCP: ☐ **Yes** ☐ **No**

Referring provider information **Referral Date:** _____

Referring provider's name (Last, First, Degree):	Office contact name:	Office contact phone:
Office address:	Office phone:	Office fax:
City:	State:	Zip:
License number:	NPI number:	Primary specialty:

Patient information

Patient last name:	Patient first name:	Date of birth:	Gender:	SSN:
Address:		Home phone number (with area code):		Work/cell phone:
City:		State:		Zip:
If minor, name of parent/caregiver/guardian:		Interpreter needed: ☐ Yes ☐ No		Language:

Insurance/authorization information

Insurance/plan name:	Group number:	Prior authorization number:
Subscriber name/date of birth:	Subscriber member ID number:	Number of visits authorized/expiration date:
Secondary insurance/plan name:	Group number:	Prior authorization number:
Subscriber name/date of birth:	Subscriber member ID number:	Number of visits authorized/expiration date:

Consultation request information

Requested specialty and name of UC Davis provider (if known):	ICD-10 code(s):	ICD-10 code(s):	ICD-10 code(s):
Service requested: ☐ Consultation ☐ Second opinion ☐ Surgery ☐ Other:	Reason for referral:		

Worker's compensation

Work related: ☐ Yes ☐ No If "Yes," carrier name:		
Carrier address:		
Adjuster name:	Adjuster phone number:	Claim number:
Date of injury:	Employer name:	

Form completed by: _____ Phone: _____ Fax: _____ Email: _____