UC DAVIS HEALTH

# Telehealth Services
## Referral Request Form

**Date of Request:**_____

**To avoid delays in the scheduling process, please:**

- Complete this referral form in its entirety and submit prior to scheduling.
- Attach a copy of the patient's insurance card and authorization form.
- Attach the completed Medicare Secondary Payer Questionnaire (MSPQ) form if necessary.
- Attach all pertinent medical records as specified in the referral guidelines.

**To:** UC Davis Health Telehealth Coordinator
**Phone:** 877-430-5332, Option 1
**Fax:** 866-622-5944
**Email:** telehealth@health.ucdavis.edu

**From:**_____
**Clinic:**_____
**Phone:**_____
**Fax:**_____

Appointment Date and Time:_____
Specialty Requested:_____ ☐ New Patient ☐ Follow-Up
Reason for Consult **(ICD-10 Required)**:

**Patient Information**

Patient Name:_____
Has patient ever been seen by UC Davis Health under a different name? ◯ Yes ◯ No
If yes, under what name:_____
DOB:_____ Gender_____ Marital Status:_____
Address:_____ Home Phone:_____
City, State, Zip:_____ Work Phone:_____
Preferred Language:_____
Primary Care Provider (PCP) Name:_____

**Guarantor Information (If different from patient or if patient is younger than 18 years old)**

Guarantor Name:_____ DOB:_____
Relationship to Patient:_____
Address:_____ Home Phone:_____
City, State, Zip:_____ Work Phone:_____

**Insurance Information (Medicare patients – fax completed MSPQ prior to or at time of appointment)**

| | Primary | Secondary |
|---|---|---|
| **Name of Insurance** | | |
| **Policy Number** | | |
| **Policy Holder** | | |
| **Date of Birth** | | |
| **Relationship to Patient** | | |

**Authorization Information (Required for managed care patients)**
**UCDMC Tax ID# 680334324 / NPI# 1710918545 / CPT Codes: 99201-99205 and 99212-99215**

Authorization Number:_____ Expiration Date:_____

**Referring Physician Information**

Full Name and Title:_____ License Number:_____
Supervising MD/DO:_____ License Number:_____
Address:_____ Phone Number:_____
City, State, Zip:_____ Email:_____