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:_____