Clinical Telehealth Program
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@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:________________