

UCI University Physicians and Surgeons

P.O Box 450 La Verne, CA 91750

Tel: (714) 509-2001 Fax: (800) 299-8780

Submitted By: _____	Phone #: _____
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DATE: _____ ADMISSION/SERVICES DATE: _____ HEALTH PLAN: _____

☐ NON-URGENT

☐ RETROSPECTIVE

☐ URGENT (Defined as "A situation where the time frame of the standard decision-making process could **seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee's ability to regain maximum function.**")

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____
STREET CITY STATE ZIP

PATIENT'S TEL: () _____ MEMBER #: _____

PRIMARY INSURED'S NAME: _____

PCP: _____ ADDRESS: _____ PHONE # () _____ FAX #: () _____	REFERRING M.D.: _____ ADDRESS: _____ PHONE #: () _____ FAX #: () _____	REQUESTED SPECIALIST: _____ ADDRESS: _____ PHONE #: () _____ FAX #: () _____
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☐ CONSULT ☐ FOLLOW-UP VISIT#: _____

☐ TOTAL OB CARE: _____
EDC/LMP

☐ PT/OT/ST VISIT(S) # FREQUENCY: _____

☐ PROCEDURE/SURGERY: _____

DIAGNOSIS/ICD-10: _____

REQUESTED PROCEDURE(S)

CPT CODE(S): (Must be included)

(1) _____

(1) _____

(2) _____

(2) _____

(3) _____

(3) _____

MEDICAL NECESSITY INFORMATION: _____

REFERRING PHYSICIAN SIGNATURE

ATTACH DOCUMENTATION TO FACILITATE DETERMINATION OF REFERRAL

UTILIZATION MANAGMENET COMMITTEE DECISION

UM COMMITTEE DECISION: ☐ APPROVED ☐ DENIED ☐ DEFERRED ☐ MODIFIED

COMMENTS: _____

UM REPRESENTATIVE SIGNATURE: _____ DATE: _____

ALWAYS VERIFY ELIGIBILITY PRIOR TO RENDERING SERVICE. PLEASE SUBMIT CLAIMS TO:
P.O. BOX 450, LA VERNE, CA 91750

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