UCI University Physicians and Surgeons

P.O Box 450 La Verne, CA 91750
Tel: (714) 509-2001 Fax: (800) 299-8780

Submitted By:	**Phone #:**

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:_____	REFERRING M.D.:_____	REQUESTED SPECIALIST:_____
ADDRESS:_____	ADDRESS:_____	ADDRESS:_____
PHONE # (___)_____	PHONE #: (___)_____	PHONE #:(___)_____
FAX #: (___)_____	FAX #: (___)_____	FAX #: (___)_____

☐ 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 REPRESENTATTIVE SIGNATURE:_____DATE:_____

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