Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Referral Request Form

Attn: Referral Center
Tel: (800) 995-5724 Fax: (650) 721-2884

Pediatric Audiology

** You can register for Stanford Children's Health MD Portal (https://mdportal.stanfordchildrens.org) to submit referrals and track appointments online.*

◯ **Medically URGENT/PRIORITY**— call Referral Center to expedite: (800) 995-5724
◯ Routine

Referring Provider

Referring MD/NP/PA: ____________ ____________ ____________ ____________
LAST NAME FIRST NAME TELEPHONE FAX

Please indicate your relationship to the patient: ◯ PCP ◯ Other: ____________
SPECIALTY

____________ FORM COMPLETED BY | __ __ / __ __ / __ __ __ __ DATE

Referring to Pediatric Audiology

In order to schedule a patient in Pediatric Audiology the insurance authorization (if required by the insurance) must be in place for the required procedure CPT codes (see list).

Note: Please refer patients for speech delays and failed screenings at school to Audiology first. Referring to ENT first may delay the patient having audiology screening.

Procedure Requested (Stanford Children's Health Audiology performs Diagnostic Testing)

Referral Diagnosis (**Required**): ____________

ICD10 (**Required**): [Letter] [Number] [Number] . [Letter or Number] [Letter or Number] [Letter or Number] [Letter or Number] (min 3 & max 7 characters)

HMO or a Managed Care Medical patients **require** the following procedure CPT codes to be authorized from the patient's insurance according to their age group:

	Procedure	Age	CPT codes
◯	Newborn Hearing Screening:		92586, 92587, 92567
◯	Newborn Hearing Evaluation	0–6mos:	92585, 92587, 92576
◯	Pediatric Hearing Evaluation	6mos–2½yrs:	92579, 92555, 92587, 92576
◯	Pediatric Hearing Evaluation	2½–5yrs:	92582, 92556, 92587, 92576
◯	Pediatric Hearing Evaluation	5yrs & Older:	92557, 92587, 92576

Please remember to fax authorization. Please reference above CPT codes for different age groups to ensure authorization covers each CPT code.

Required Patient Information

◯ Female ◯ Male Stanford Children's Health Medical Record: ____________ (IF AVAILABLE)

Interpreter required for either patient or parent/guardian? ◯ Yes ◯ No ____________ PATIENT LANGUAGE ____________ PARENT/GUARDIAN LANGUAGE

____________ LAST NAME ____________ FIRST NAME ____________ MIDDLE NAME

Date of Birth: __ __ / __ __ / __ __ __ __ Age: ______

Patient's Address: ____________ City/State/Zip: ____________

Patient's Phone: ____________ HOME/CELL/WORK Alternate Phone: ____________ HOME/CELL/WORK

Guardian Name: ____________ Guardian Relationship: ____________

Insurance Information

◯ Self Pay **PLEASE INCLUDE A LEGIBLE COPY OF THE INSURANCE CARD (BOTH SIDES), AND AUTHORIZATION IF REQUIRED.**

Guarantor same as Subscriber? ◯ Yes ◯ No ____________ (PERSON FINANCIALLY RESPONSIBLE FOR PATIENT) Guarantor Relationship: ____________

Guarantor DOB: __ __ / __ __ / __ __ __ __

Authorization Required: ◯ Yes ◯ No #Visits Authorized: ______ Auth#: ____________

Authorization Expiration Date: __ __ / __ __ / __ __ __ __