

## 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**

Routine

### Referring Provider

Referring MD/NP/PA: \_\_\_\_\_  
LAST NAME FIRST NAME ext TELEPHONE FAX

Please indicate your relationship to the patient:  PCP  Other: \_\_\_\_\_  
SPECIALTY

FORM COMPLETED BY \_\_\_\_\_

DATE \_\_\_\_\_

### Referring to Pediatric Audiology

### Procedure Requested

(Stanford Children's Health Audiology performs Diagnostic Testing)

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 hearing screenings to Audiology first. Referring to ENT first may delay the patient having a diagnostic hearing evaluation.

Referral Diagnosis (**Required**): \_\_\_\_\_

ICD10 (**Required**): 

↓ Letter	↓ Number	↓ Letter	↓ Number	↓ Letter	↓ Number	↓ Letter	↓ 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:

- Newborn Hearing Screening: 92586, 92587, 92567
- Newborn Hearing Evaluation | 0-6mos: 92585, 92587, 92567
- Pediatric Hearing Evaluation | 6mos-2½yrs: 92579, 92555, 92556, 92587, 92567
- Pediatric Hearing Evaluation | 2½-5yrs: 92582, 92555, 92556, 92587, 92567
- Pediatric Hearing Evaluation | 5yrs & Older: 92557, 92570, 92587, 92567

**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: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
HOME | CELL | WORK (circle/click) HOME | CELL | WORK (circle/click)

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: \_\_\_\_\_

Authorization Required:  Yes  No      #Visits Authorized: \_\_\_\_\_ Auth#: \_\_\_\_\_

Authorization Expiration Date: \_\_\_\_\_