Stanford MEDICINE
Children's Health

Referral Request Form

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

Pediatric Audiology

** You can register for Stanford Medicine 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

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.

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

Referral Diagnosis (**Required**): _____

ICD10 (**Required**): Letter 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:

◯ 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 ◯ Other Stanford Children's 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 (circle/click)) Alternate Phone: _____ (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: _____

Guarantor DOB: _____

Authorization Required: ◯ Yes ◯ No #Visits Authorized: _____ Auth#: _____

Authorization Expiration Date: _____