SANTA CLARA COUNTY HEALTH AND HOSPITAL SYSTEM

AUTHORIZATION CENTER

5750 Fontanoso Way
San Jose, CA, 95138
PHONE: (669) 299-8230
FAX: (408) 793-1892

FAX

To: ______________________________ From: ________________________

Fax: _____________________________ Pages: _______________________

Phone: ___________________________ Date: ________________________

Re: ____

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

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Dear Provider,

Thank you for your interest in referring your patient to VMC. Due to change in policy all referrals to VMC must be on a VMC Referral form otherwise referral will not be accepted. Attached is our Consultation/Referral Form and the Registration Form. (This is pertinent in order to expedite your request)

Please complete both forms and fax back to The Authorization Center at (408)793-1892.

- Routine or Urgent? Urgent, requires MD to MD communication see Referral form for instructions
- Reason for Referral: Must be pertinent to diagnosis if not legible Auth Ctr staff will call your office if incomplete referral will be faxed back
- Current Demographic Information (if minor, please provide Parent/Guardian name and DOB)
- Progress Notes (include Reports: lab, x-ray, CT scan, ultrasound, mammogram etc. pertinent to diagnosis.)
- ICD-10 Code(s)
- Copy of Insurance Card or Insurance Information
- If Manage Care Coverage Approved Authorization from Managing Agency (Excel, SCCIPA, CAP, etc.)
- Specialty you are referring to.
- Print First & Last name of referring Provider, LIC# & UPIN# and TAX ID

Please note that the referral will not be processed until all information Is received. Referrals received incomplete or illegible will be returned. Thank you.

REQUEST FOR CONSULT / REFERRAL

Patient Name: ______________________________________
Patient DOB: _______________________________________
Address: ____
____
____

Phone: ____
Medical Record #: ___________________________________
Insurance Type or Coverage: ___________________________
____

Date: ___________________________

ORIGINATING CLINIC

Attending MD *Resident, PA & NP requires attending signature*	**Referring Clinic**
MD Name: ___________________________ MD Signature: ________________________ LIC #: ______________________________ NPI #: ______________________________	Clinic Name: _______________________________________ Address: ____ ____ Phone: ____ Fax: ____

STOP – All pertinent information must be complete & legible, or this referral will not be processed.

☐ **CONSULT** (Requesting opinion about a specific problem; requires feedback from consultant to provider initiating consult.)
☐ **REFERRAL** (Transferring care for a specific problem to another provider.)

Requested for: ____
(What Specialty)

☐ Routine ☐ Within One Month ☐ Within Two Weeks ***Requires prior conversation w/ Specialist.**
(Print name of specialist and date of conversation below.)

☐ ICD 10 1) _______ 2) _______

3) _______ 4) _______

______________________ ______________________
Specialist's Name Date

REASON FOR CONSULT / REFERRAL

(PLEASE INDICATE REASON FOR REFERRAL ALONG WITH ATTACHED PROGRESS NOTES, PERTINENT LABS, XRAYS, etc.)

____
____
____
____
____

Please Fax Referral with all the listed information below to (408) 793 – 1892

☐ Current Demographic Information (Face Sheet
☐ Progress Notes
☐ Reports (Labs, X-Ray & etc.)
☐ Approved Authorization
☐ Copy of Insurance Card

Original to Chart – Copy to SCVMC Referral Center

THIS FORM MUST BE FILLED OUT COMPLETELY

PATIENT'S DEMOGRAPHIC INFORMATION:

LAST NAME: ______________________ FIRST: ______________________ MIDDLE: __________

DATE OF BIRTH: ______________________ SOCIAL SECURITY #: ______________________ SEX: ☐ M ☐ F

HOME ADDRESS: ______________________ CITY: ________________ STATE ____ ZIP CODE ________

HOME PHONE / CELL #: (____) ______________________ BIRTH PLACE: ______________________

U.S. CITIZEN: ☐ Y ☐ N MARITAL STATUS: ____________ ETHNICITY: ________ COUNTY: ____________

RELIGION: ____________ LANGUAGE: ____________ MOTHER'S MAIDEN NAME (LAST): ______________

ARE YOU EMPLOYED: ☐ Y ☐ N EMPLOYER NAME: ____________________ OCCUPATION: ____________

INSURANCE INFORMATION: (PPO, HMO, MEDI-CAL, & HEALTH FAMILY OR KIDS)

INSURANCE TYPE: ______________________ GROUP #: ______________ PHONE: (____) __________

I.D. #: ________________ SUBSCRIBER'S NAME: ______________________ DATE OF BIRTH: __________

EMPLOYER NAME: ________________________________ OCCUPATION: ______________________

INSURANCE BILLING ADDRESS: ____

GUARANTOR'S INFORMATION:

NAME: ____ RELATIONSHIP: ________________

SOCIAL SECURITY #: _________________________________ DATE OF BIRTH: ________________

EMERGENCY CONTACT PERSON: (DIFFERENT TELPHONE # FROM PT)

NAME: ____ RELATIONSHIP: ________________

PHONE / CELL #: (_____) ________________

PLEASE FILL OUT THE INFORMATION ABOVE AND FAX IT BACK TO VMC AUTH DEPT. AS SOON AS POSSIBLE. REGISTRATION FORM MUST BE COMPLETED & RETURNED TO VMC AUTHORIZATION DEPARTMENT BEFORE YOUR APPOINTMENT. PLEASE FAX IT TO **(408) 793-1892**. THANK YOU!