



CPSS Referral Form

To: California Pacific Specialty Services (CPSS)
Phone: (888) 637-2762, Fax: (415) 600-2955

From: Referring Physician: _____
Contact Person: _____
Address: _____
Phone and Fax: _____

Patient Information

Patient's Name: _____ DOB: ____/____/____
Insured's Name: _____ SSN: ____-____-____
Phone: (h) _____ (w) _____
Street Address: _____
City/State/Zip: _____

Diagnosis: _____ ICD-9: _____
Reason for Referral/Hx & PE: _____

Specialty and/or Physician Requested: _____

Insurance Information - please attach copy of insurance card

Health Plan: _____ Product Type: _____
Medical Group: _____ Auth. #: _____
visits: _____ Effective dates: _____ to _____ ID #: _____
Services Authorized: _____
(for consultation please use CPT code 99245 and for follow-up please use CPT code 99214)

Checklist:

- ____ patient information sheet (demographics)
- ____ copy of insurance card(s)
- ____ pertinent medical records