Referral Form

Sutter Health
West Bay Region

To: **Regional Referral and Transfer Center**
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 99244 and for follow-up please use CPT code 99214)

Checklist:

____ patient information sheet (demographics)

____ copy of insurance card(s)

____ pertinent medical records