Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Referral Request Form

Attn: Referral Center
Tel: (800) 995-5724 Fax: (650) 721-2884
E-mail: referral@stanfordchildrens.org

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**— call Referral Center to expedite: (800) 995-5724

◯ Routine

Referring Provider

Referring MD/NP/PA: _____ (LAST NAME) _____ (FIRST NAME) _____ (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 screenings at school to Audiology first. Referring to ENT first may delay the patient having audiology screening.

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, 92576
◯ Pediatric Hearing Evaluation	6mos–2½yrs:	92579, 92555, 92587, 92576
◯ Pediatric Hearing Evaluation	2½–5yrs:	92582, 92556, 92587, 92576
◯ Pediatric Hearing Evaluation	5yrs & Older:	92557, 92587, 92576

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: _____ (HOME/CELL/WORK) Alternate Phone: _____ (HOME/CELL/WORK)

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: ___/___/_____