REFERRING A PATIENT

ORTHOPEDICS & SPORTS MEDICINE

Thank you for choosing Tahoe Forest Health System and for referring your patient to us. We appreciate the opportunity to partner with you in your patient's care.

To begin the referral process, please complete our referral intake form and fax it to our Physician Referral Center at **(530) 550-1670**.

Please allow up to 5 - 7 business days to process your referral. Please be advised incomplete information or need for clarification may delay the process.

If this in an **URGENT** request, please call the Physician Referral Center at **(530) 582-4902**.

Checklist for Non-Urgent Referrals

Prior to submitting a referral, please complete the following:

- ❑ Obtain insurance plan authorization
- ❑ Confirm patient name and name on the insurance card(s)
- ❑ Obtain copy of most up-to-date insurance card(s)

Please submit the following with your request:

- ❑ Completed TFHD referral intake form
- ❑ Recent/relevant typed clinical notes/test results
  - ❑ Health history
  - ❑ Physical
  - ❑ MRI
  - ❑ CT
  - ❑ X-ray
  - ❑ EMG
  - ❑ Other related exams
- ❑ Proof of insurance
- ❑ Authorization information with CPT code details and approved visits

Please fax all of the documents to the Physician Referral Center at **(530) 550-1670**.

REFERRAL INTAKE FORM

TAHOE FOREST
HEALTH SYSTEM

Please fax this completed form and referral packet to (530) 550-1670.

Are you the patient's primary care provider? ❑ Yes ❑ No

REFERRING PROVIDER INFORMATION

Referring Provider's Name (Last, First, Degree):	Office Contact Name:	Office Contact Phone:
Office Address:	Office Phone:	Office Fax:
City:	State:	Zip:
Facility NPI:	Provider NPI:	Primary Specialty:

PATIENT INFORMATION

Patient Last Name:	Patient First Name:	Date of Birth:	Gender:	SSN:
Address:	Home Phone Number:	Work Phone Number:	Cell Phone Number:	
City:		State:	Zip:	

IF PATIENT IS A MINOR, PARENT/CAREGIVER/GUARDIAN INFORMATION

Name of Parent/Caregiver/Guardian (Last Name, First Name):	Date of Birth:	Gender:	SSN:
Employment Status:	Employer:		

INSURANCE INFORMATION

Insurance/Plan Name:	Group Number:
Subscriber Name/Date of Birth:	Subscriber Member ID Number:
Secondary Insurance/Plan Name:	Group Number:
Subscriber Name/Date of Birth:	Subscriber Member ID Number:

INSURANCE AUTHORIZATION INFORMATION

Authorization Number:	Authorization Dates:

CONSULT INFORMATION

Requested Specialty and Name of TFHD Provider (If Known):	ICD-10 Code(s):
Service Requested: ❑ Consultation ❑ Second Opinion ❑ Other: _____	

Form Completed By: _____ Phone Number: _____