



2222 BANCROFT WAY # 4300  
BERKELEY, CA 94720-4300

510 642-5700

[www.uhs.berkeley.edu](http://www.uhs.berkeley.edu)



**STUDENT HEALTH INSURANCE  
REFERRAL AUTHORIZATION REQUEST FORM**

**Fax WITH MEDICAL NOTES to 510-642-9119**

**REFERRAL AUTHORIZATION WILL NOT BE PROCESSED  
WITHOUT MEDICAL NOTES SUPPORTING REQUEST**

- Routine Request = within 5 working days we will fax back a determination to the fax provided on this form.  
 Expedited/STAT Request = Date of Service >48 hours would seriously jeopardize the life of the member.  
 Physician must document reason why the standard review time frame could seriously jeopardize the life or health of the member: \_\_\_\_\_

**TODAY'S DATE:**

**Section A. STUDENT INFORMATION**

Student Name:	Date of Birth:	Aetna Student Health ID Number: <b>W</b>
	SHIP Patient #: (if known)	Aetna Student Health Group Number: <b>474941</b>

**Section B. REQUESTING PROVIDER**

Provider Name:	Provider Specialty:	Provider Phone:	Provider Fax:
Provider Address:	Provider City:	Provider Zip:	Contracted with Aetna? (Please circle one) YES      NO

**Section C. REFERRED TO PROVIDER (Leave blank if the same as requesting provider)**

Referred to Provider Name: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Provider Specialty:	Referred to Phone:	Referred to Fax:
Referred to Provider Address:	Referred to Provider City:	Referred to Zip:	Contracted with Aetna? (Please circle one) YES      NO

**Section D. REFERRED TO FACILITY (if applicable or required if a surgical procedure)**

Referred to Facility Name: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Date of admission/procedure:	Referred to Phone:	Referred to Fax:
Referred to Facility Address:	Referred to Facility City:	Referred to Zip:	Contracted with Aetna? (Please circle one) YES      NO

**Section E. SERVICES REQUESTED**

Primary diagnosis related to the service(s) requested (please only indicate one diagnosis):		Corresponding Diagnosis Code (ICD-9):
Service(s) being requested (Please use CPT codes and descriptions):		Number of visit(s) or length of stay:
Are services being requested RETROACTIVELY? (Please circle one) YES      NO	If services are being requested RETROACTIVELY please indicate the dates of service(s) that are being requested, if no dates are indicated it will be assumed your request is for future date(s) of service.	

**CONFIDENTIALITY NOTICE:**

The documents accompanying this facsimile transmission may contain confidential information belonging to the sender. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of the faxed information is strictly prohibited. If you have received this fax in error, please notify us by telephone. 11/2013