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STUDENT HEALTH INSURANCE PLAN
REFERRAL APPROVAL REQUEST FORM

Fax WITH MEDICAL NOTES to 510-642-9119

Request will NOT be processed without supporting medical notes.

☐ 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:	Anthem ID Number:

Section B. Who is requesting this referral? (Does not have to be patient's PCP.)

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

Section C. Who do you want to refer the patient to see? (Leave blank if same as requesting provider.)

Referred to Provider Name: ☐ Inpatient ☐ Outpatient	Provider Specialty:	Referred to Phone:	Referred to Fax:
Referred to Provider Address:	Referred to Provider City:	Referred to Zip:	Contracted with Anthem? (Please circle one) YES NO

Section D. Are you also referring pt to a facility? (if applicable or required e.g. for surgical procedure)

Referred to Facility Name: ☐ Inpatient ☐ Outpatient	Date of admission/procedure:	Referred to Phone:	Referred to Fax:
Referred to Facility Address:	Referred to Facility City:	Referred to Zip:	Contracted with Anthem? (Please circle one) YES NO

Section E. Services requested

Primary diagnosis related to the service(s) requested (please only indicate primary diagnosis):	Corresponding Diagnosis Code (ICD-10):
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.

☐ Check box if services requested are related to intercollegiate athletics.