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510-664-9089
uhs.berkeley.edu

STUDENT HEALTH INSURANCE PLAN
TRANSGENDER PRE-CERTIFICATION REQUEST FORM

Fax to 510-642-9119

Request will NOT be processed without required supporting documentation.

Today's date: _____________

Section A. Student information

Student Name:	Date of Birth:	SHIP (Wellfleet) ID Number:

Section B. Requesting Provider Information

Name:	Specialty:	Phone:	Fax:
Address:		In CA: Contracted with Blue Shield? ☐ YES ☐ NO Outside of CA: Contracted with Cigna? ☐ YES ☐ NO	

Section C. Referred to Facility

Name: ☐ Inpatient ☐ Outpatient	Date of admission/procedure:	Phone:	Fax:
Address:		In CA: Contracted with Blue Shield? ☐ YES ☐ NO Outside of CA: Contracted with Cigna? ☐ YES ☐ NO	

Section D. 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:

CONFIDENTIALITY NOTICE:

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