

Sierra Vista Regional Medical Center
 Pediatric Specialty Clinic
Outpatient Registration
(805) 546 – 7692
 1010 Murray Avenue · San Luis Obispo · CA 93405
OUTPATIENT MEDICAL SERVICES FAX REQUEST
FAX TO: 805 546-7682

Thank you for referring to the Pediatric Specialty Clinic at Sierra Vista Regional Medical Center. Prior to scheduling any appointment, we ask that all patient information and authorizations be faxed to (805) 546-7682 for processing. You will be notified via fax of the appointment date/time. If you have questions regarding this appointment, please contact the clinic at (805) 546-7692. Please send all patient records pertinent to the diagnosis, including lab reports, x-rays reports, growth charts, EKGs, and EEGs.

Please attach the signed MD order for all Diagnostic testing AND obtain prior authorization for services

Date : _____ Contact person: _____
 Referring Physician: _____
 Phone # : _____ Fax # : _____
 Patient Name : _____ (first) _____ (last) DOB : _____ M F
 Primary Language: _____ Interpreter needed? Yes No
 CCS Coverage: Yes No County : _____ CCS Dx: _____
 Chief Complaint/Reason for Visit: _____ ICD 9 (required) _____
 New to Sierra Vista? Yes No Sierra Vista MR # if known : _____
 Clinic/Service Requested: _____
 Consult & Treat Consult, Treat, Test Consult only Follow-up Visits : _____ (number of visits authorized)
 Diagnostic Test: _____ Name of Test: _____ CPT 4 _____
 Patient SS# _____ Phone # _____ Alternate # _____
 Address _____
 City _____ Zip Code _____
 Insurance Name : _____
 Subscriber: _____
 ID # _____ Group # _____ Insurance IPA _____
 Employer: _____
 Mother's Name _____ DOB _____
 SS # _____
 Father's Name _____ DOB _____
 SS # _____
 Cin # (Medi-Cal required): _____

Fax Checklist

- | | |
|---|---|
| <input type="checkbox"/> Demographics completed | <input type="checkbox"/> Authorized Diagnosis |
| <input type="checkbox"/> Prior Authorization obtained for services | <input type="checkbox"/> Copy of insurance card, front & back |
| <input type="checkbox"/> Signed MD order for DX test(s) | <input type="checkbox"/> Patient SS # |
| <input type="checkbox"/> Mother's & Father's name/DOB | <input type="checkbox"/> PFT ordered: if 6 years or older |



Patient Label (Sierra Vista)