UCSF Benioff Children's Physicians

Maternal-Fetal Medicine

MATERNAL-FETAL SERVICES REFERRAL FORM

2920 Telegraph Ave, Suite 200, Berkeley, CA 94705
Telephone (510)444-0790 or (888) 598-8227 • Fax (510) 267-1926

REFERRING PROVIDERS PLEASE PROVIDE THE FOLLOWING:

□ **ALL PRENATAL RECORDS INCLUDING:**
- **PREGNANCY RELATED LABS AND ULTRASOUND REPORTS**
- **PREVIOUS PREGNANCY C-SECTION OP REPORTS** *(if applicable)*
- **STERILIZATION CONSENT FORM** *(if applicable)*

□ **PRIOR AUTHORIZATION APPROVAL ACCORDING TO PATIENT'S INSURANCE**

□ **COPY OF PATIENT DEMOGRAPHICS AND BOTH SIDES OF THE PATIENT'S INSURANCE CARD**

PLEASE COMPLETE FORM IN ITS ENTIRETY AND PROVIDE ALL REQUIRED DOCUMENTS TO AVOID DELAYS IN SCHEDULING

PATIENT INFORMATION

Patient Name _____ **DOB** _____ **Phone** _____

LMP_____ EDC_____ Gravida _____ Para _____ Vag_____ C/S _____

PROVIDER INFORMATION

Provider Name (**Print**) & Facility Name: _____ Date: _____

*Provider Signature (**Required**)*: _____ Phone: _____ Fax: _____

SERVICE TYPE REQUESTED

**** Complete additional section below for *Sweet Success* ****

☐ **Preconception** □ **Consultation** □ **Consult and Co-Managed Care** □ **Transfer of Care**

☐ **Cerclage Consultation with Ultrasound if clinically indicated**

Reason for Visit or Diagnosis:

_____

_____

_____

FOR DIABETES REFERRALS:

- **Is this a *Sweet Success* referral?** □ YES □ NO
- **Was the patient diagnosed with diabetes before this pregnancy?** □ YES □ NO
- **Specify service type requested** □ Consultation □ Consult and Co-Managed Care □ Consult and Transfer of Care

LAB RESULTS (REQUIRED) ***Please enter GDM diagnostic test results your office completed***

First Trimester Diabetes Screening (<14 weeks) **Date**_____ **HgbA1C** _____

- **2 Hr GTT** Date_____ Results FBS _____ 1 Hr _____ 2 Hr _____
- **1 Hr GLT** Date_____ Results 1 Hr _____
- **3 Hr GTT** Date_____ Results FBS _____ 1 Hr _____ 2 Hr _____ 3 Hr _____

Please see second page for instructions on obtaining Prior Authorizations

Obtaining Authorization(s) for MFM Services

To obtain a prior authorization for services at UCSF Benioff Children's Physicians Maternal-Fetal Medicine, please note the specific information you will need below:

1. We are contracted under the business name: **BayChildren's Physicians** – please give this as our MFM practice name
2. **NPI: 1922124866**
3. **Tax ID # 86-1175591**
4. **Frequently used CPT Codes – see below**

Please complete the following as applicable:		
CPT Code	**Description**	**Amount of Time/Time Period Approved**
☐ 99203-99205	Maternal Fetal Medicine New Patient Visit/Transfer of care.	
☐ 99243-99245	Consultation Initial Evaluation	
☐ 99213	Follow up visits for transfers or comanage	8-13 visits depending on gestational age
☐ G0108	Diabetic Outpatient Self Mgmt Training Svc, Individual, Per 30 min.	
☐ G0109	Diabetic Outpatient Self Mgmt Training Svc, Group Session, Per 30 min.	
☐ 97802	Medical Nutrition Therapy, Initial Assessment & Intervention, Individual, Per 15 min.	
☐ 97803	Medical Nutrition Therapy, Initial Reassessment & Intervention, Individual, Per 15 min.	8-13 visits depending on gestational age
☐ 97804	Medical Nutrition Therapy, Group Session, Per 30 min.	

Authorization notes: