Exhibit B
Clinical Information-County/Hospital District Referral Form

Date: _____ **Form initiated by:** _____ (county/dist.) **Ph #:** _____ **Fax #:** _____

Faculty/PCP: _____ *Provider #:* _____ *Ph. #:* _____ *fax #:* _____

SCP: _____ *Provider #:* _____ *Ph. #:* _____ *fax #:* _____
(Specialty Physician's Name)

Select appropriate request: **Approval for:** Procedure [ ] Referral [ ]
Consultation [ ] More Visits [ ]

Procedure/Service Requested: _____

_____ **CPT:** _____

Diagnosis: _____ **ICD-9:** _____

Symptoms: _____
_____

Pertinent History: _____

Previous Treatments: _____

Current Meds: _____

Treatment Plan: _____

Financial Information

County/District Name: _____ Phone #: _____
County/Dist rep's name: _____ Patient's Phone #: _____
Patient Name: _____ SS#: _____
Authorization #: _____ County #: _____ Case in computer? **Y / N**
No. of visits approved: _____ Expiration date of approval: _____
Other pertinent information: _____
_____

Appointment made? **Y / N** Patient notified? **Y / N**
Date/Time of Appointment: _____
IF denied, MD notified? **Y / N** IF denied, patient notified? **Y / N**

Authorization obtained by: _____ Date: _____

Write in Patient Information/Affix Label:

Name: _____

UH#: _____

Contract Care Approval Form

The University of Texas
Medical Branch Hospitals & Clinics
Galveston, Texas