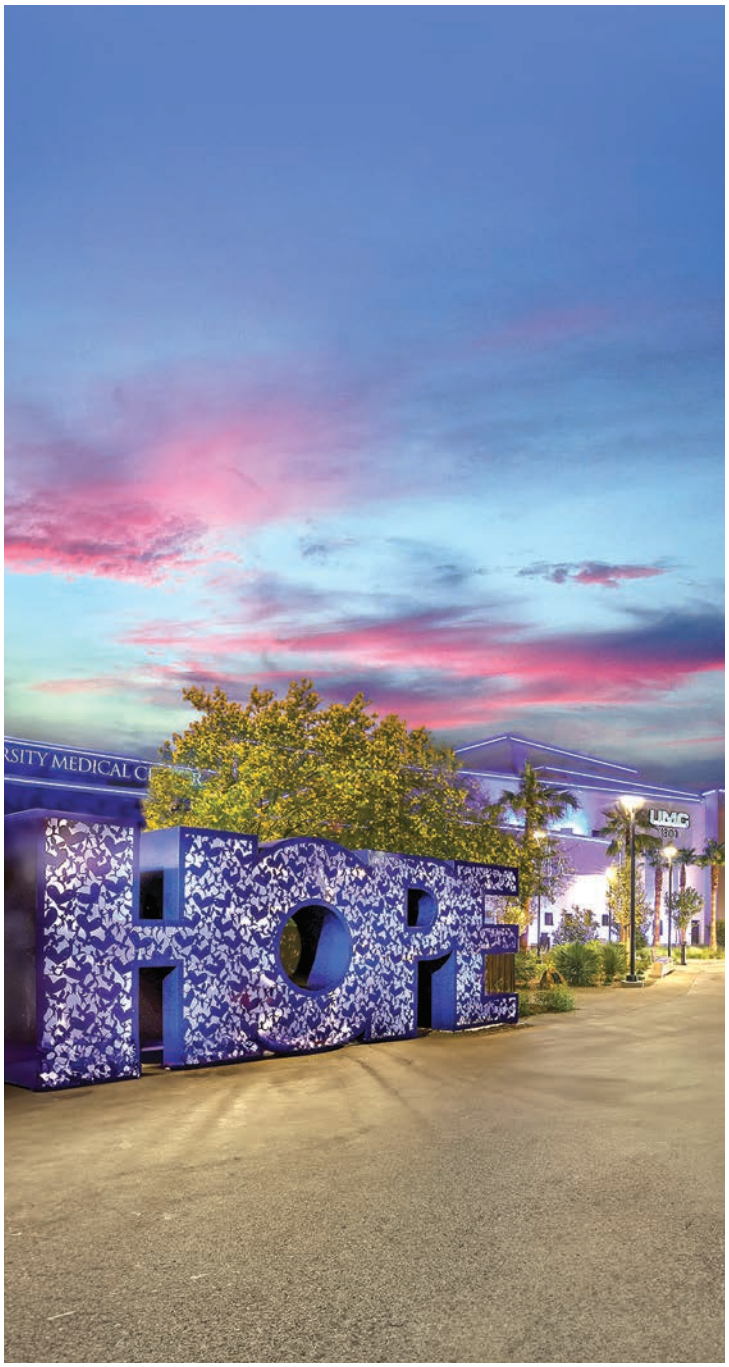
MEDICAL REFERRAL FORM

UMC UNIVERSITY MEDICAL CENTER

LIVER CARE CENTER



Expert Care and Treatment
of Liver Diseases

DATE:_____ ☐ **STAT**

REFERRING:

PROVIDER NAME:_____

OFFICE CONTACT NAME:_____

PHONE: _____

FAX: _____

REFERRAL TO:

UMC Liver Care Center
901 RANCHO LANE, STE. 250
LAS VEGAS, NV 89106
PHONE: 702-383-2550 FAX: 702-383-1876

PATIENT:

NAME: _____

DATE OF BIRTH: _____

PHONE: _____

PRIMARY INSURANCE: _____

_____

POLICY #:_____ AUTH: _____

SECONDARY INSURANCE: _____

POLICY #:_____ AUTH: _____

DIAGNOSIS CODE(S) (ICD-10) _____

_____

ADDITIONAL INSTRUCTIONS:_____

_____

_____

_____

_____

Submit

You may also fax completed form to: 702-383-1876.

Current labs and a current H&P or most recent clinic visit notes are required in order to process a referral.

For questions, please call 702-383-2550.

TRP-2025-0004