UC San Diego Health



Patient Identification

TRANSFER NOTIFICATION AND AGREEMENT

 test results and all requested/appropriate diagnostic films to accompany the patient. The transferring facility will not transfer the patient until the receiving physician has consented to accept the and the transfer has been cleared by the Transfer Center. The transferring facility will ensure that the patient is medically stable and suitable for all procedures and that the time of transfer. This will confirm that the transferring facility and referring physician agree to accept the patient in return the UCSDH's request after specialty services provided by the UCSDH have been completed. UCSDH Physicial transfer the patient back after they determine the patient can be safely treated within the capabilities of the transferring facility or its physicians are unwilling/unable to accept the patient back at the transferring facility guarantees it will reimburse the UCSDH and its physicians for any services or days denied or not covered by the patient's insurer, at the insurer's customary reimbursement rate. In the installing patient is uninsured/covered, the UCSDH Medi-Cal per diem rate will apply. 	Transferring Facility:			Date of Transfer:			
Patient's Name: 1. This is to confirm that UC San Diego Health (UCSDH) has received a request to accept the above patient of from your facility. 2. The transferring facility will provide a summary, a copy of the appropriate portions of the medical record, of test results and all requested/appropriate diagnostic films to accompany the patient. 3. The transferring facility will not transfer the patient until the receiving physician has consented to accept the and the transfer facility will ensure that the patient until the receiving physician has consented to accept the and the transferring facility will ensure that the patient is medically stable and suitable for all procedures and the transferring facility services provided by the UCSDH have been completed. UCSDH Physicial transfer the patient back after they determine the patient can be safely treated within the capabilities of the unsured that the transferring facility or its physicians are unwilling/unable to accept the patient back at the transferring facility guarantees it will reimburse the UCSDH and its physicians for any services or days denied or not covered by the patient's insurer, at the insurer's customary reimbursement rate. In the instale patient is uninsured/covered, the UCSDH Medi-Cal per diem rate will apply. 5. Please specify an alternate-accepting physician with phone number if the referring physician is unavailable the patient back. 7. Please specify contact person if other than the original from the transferring facility; Name: Title: Phone number: Fax:	Ref	erring Physician:		Phone:			
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Phone number: agrees to be responsible for the transportation cost Transferring Facilty to and from not covered by the patient's insurance. Receiving Facilty Print Name of Hospital Administrator or Designee	7.	Please specify contact person if other than the original from the transferring facility;					
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Signature of Hospital Administrator or Designee			not covered by	the patient's ins	surance.		
		Print Name of Hospital Administrator or Designee	Title of Hospital Administ	rator or Designee	Date	Time	
Print Name of Transferring Physician Title of Transferring Physician Date		Signature of Hospital Administrator or Designee	_				
		Print Name of Transferring Physician	Title of Transferring Phys	ician	Date	Time	

Signature of Transferring Physician or Designee