

3.19 B

Expedited Diagnostic Service Request

For Infants with a Positive Newborn Screening (NBS) Test

To: The Special Care Center (SCC)

- Metabolic
- Endocrine
- Hemoglobinopathy/Sickle Cell Disease
- Cystic Fibrosis/Pulmonary
- Immunology

The purpose of this request is to expedite the diagnostic evaluation for an infant with a positive newborn screening test. **The CCS program will authorize these evaluations, but due to the scheduled appointment occurring quickly, the SCC may not have the authorization at the time of the visit.** The authorization will be forthcoming.

The infant named below will be scheduled for a diagnostic evaluation with the following SCC:

SCC _____ Physician _____

SCC Contact _____ Fax _____

Date of Visit (If known) _____

Infant's Name _____ AKA _____
(as on the positive newborn screening report) (when applicable)

Infant's Date of Birth _____ NBS Number _____
(initial NBS screening test accession #)

Mother's Name _____ AKA _____
(as on the positive newborn screening report) (when applicable)

Mother's Date of Birth _____

Primary Care Provider _____ Phone _____

The attached application* must be completed by the parent/legal guardian at the time of the SCC visit and then faxed to the appropriate CCS program.

The CCS program will issue an authorization to cover the diagnostic services within five working days of receipt of all necessary documents. **The SCC shall not charge the infant's family for any services (including room fees) related to this diagnostic evaluation.**

If you have any questions, please contact the following:

NBS Coordinator _____ Phone _____

Area Service Center _____ Phone _____

Attachments: (1) CCS Application (2) Copy of the positive NBS report

*The application can also be downloaded from <http://www.dhs.ca.gov/pcfh/cms/ccs/publications.htm>. Click on DHS 4480 (English or Spanish)

cc: _____ County CCS program _____ Fax _____