**A PRIOR REFERRAL MUST BE ISSUED BY UCSD STUDENT HEALTH FOR CARE OUTSIDE OF THE UCSD STUDENT HEALTH CLINIC, WITH THE EXCEPTION OF IMMUNIZATIONS, URGENT CARE, EMERGENCY ROOM, DENTAL, AND VISION SERVICES. IF A PRIOR REFERRAL IS NOT IN PLACE AT THE TIME OF SERVICE, THE PATIENT IS FOUND FINANCIALLY RESPONSIBLE FOR ANY DENIED CLAIMS.*

UC SAN DIEGO UC SHIP
RETRO-ACTIVE REFERRAL APPEAL FORM

PLEASE FILL OUT THIS FORM AND SECURELY EMAIL IT TO SHIP3@UCSD.EDU ASAP, encrypt your email by typing **SECURE:** in the subject line. Please attach any relevant documents.
THE REQUEST WILL BE REVIEWED WITH THE EXECUTIVE MEDICAL AND MENTAL HEALTH PROVIDERS TO DELIVER A FINAL DETERMINATION. THE DECISION WILL BE DELIVERED WITHIN 5 BUSINESS DAYS FROM FILING AND THE DECISION WILL BE EMAILED TO THE REQUESTER USING THEIR UCSD EMAIL ADDRESS.

STUDENT ID NUMBER AT UCSD (A#):	
STUDENT LAST NAME:	
STUDENT FIRST NAME:	
DATE OF BIRTH:	
UCSD EMAIL ADDRESS:	
DATE(S) YOU WENT TO A PROVIDER:	
WHAT IS THE SERVICE PROVIDED: Ie; specialty care, mental health, diagnostics, etc.	
HAVE YOU RECEIVED AN EXPLANATION OF BENEFITS FROM UC SHIP/ANTHEM BLUE CROSS:	
PLEASE EXPLAIN WHY YOU DIDN'T OBTAIN A PRIOR or RENEWED REFERRAL BEFORE TO ACCESSING CARE:	