Stanford Cancer Network Program Partnership

Alameda Alliance for Health (Alliance) is thrilled to announce our new partnership with Stanford Medicine and Stanford Health Care's University HealthCare Alliance (UHA) Cancer Network Program. This partnership will allow Alliance members with oncologic or hematologic diagnoses to have access to Stanford Cancer Network specialists through both in-person and virtual visits.

The Stanford Cancer Network Program cancer specialists will provide enhanced care coordination, and streamlined access to Stanford Cancer Network surgical and medical specialists. These specialists will help remove barriers for patients to access specific, highly complex Stanford Cancer Network Program diagnostic services, and cancer clinical trials.

Who qualifies?

Any Alliance member with an oncologic or hematologic diagnoses and directly assigned to an Alliance primary care provider (PCP).

How do I refer an Alliance member who qualifies?

Alliance directly contracted providers may refer Alliance members to one of the Stanford Cancer Network Program cancer specialists listed on the next page by completing an online referral or the attached referral form. In accordance with the Alliance referral policy, care initiated by a listed provider will not require prior authorization (PA). Consultations with any Stanford Cancer Network Program subspecialists will be coordinated by Stanford clinical administration.

Online Referral Instructions

1. Log into the Stanford Referring Provider Portal – PRISM at **prism.stanfordhealthcare.org**.
2. Select your patient and complete the referral information.
3. Attach any relevant records.

You can log back into the portal to see the status of your referral at any time.

Attached Referral Form Instructions

1. Complete the Stanford Cancer Network Referral Request Form (PDF) attached.
2. Fax the completed referral form to the fax number for the specific provider, listed on the next page.

Breast Oncology Surgery

Emeryville and Pleasanton

PROVIDER NAME	PHONE NUMBER	FAX NUMBER
Dr. Daphne Ly	**1.650.498.6004**	**1.650.498.7237**
Dr. Jean Bao		

General Medical Oncology and Hematology

Pleasanton

PROVIDER NAME	PHONE NUMBER	FAX NUMBER
Dr. Rishi Sawhney	**1.925.734.8130**	**1.925.225.9520**
Dr. Kavitha Raj		

Castro Valley

PROVIDER NAME	PHONE NUMBER	FAX NUMBER
Dr. Nitin Joshi	**1.510.888.0657**	**1.510.886.4532**

Emeryville

PROVIDER NAME	PHONE NUMBER	FAX NUMBER
Dr. Ellen Chuang	**1.510.901.3552**	**1.510.806.2557**
Dr. Anjali Sibley		

The Alliance and Stanford Cancer Network specialists will meet monthly to review care of members, clinical requirements, and goals and outcomes of care. Stanford Cancer Network specialists will collaborate with Stanford Cancer Network subspecialists to facilitate members' access to applicable cancer clinical trials where members will be seen at Cancer Center Palo Alto. The Alliance will cover local ground transportation for members participating in clinical trials.

Please Note: This does not apply to members who are assigned to an Alliance delegated provider network.

For more details about the referral process, please visit the Stanford Health Care website at **stanfordhealthcare.org/health-care-professionals/referring-physicians.html**.

Stanford HEALTH CARE
STANFORD MEDICINE

Stanford Cancer Network
Referral Request Form

Thank you for choosing Stanford Health Care. We look forward to partnering with you in your patient's care. Please note which location this is for:

☐Valley Care CAP ☐SHC Emeryville ☐UHA Pleasanton ☐UHA Castro Valley

Date: _____
# of pages faxed _____

SHC Emeryville Fax: 510-806-2557
UHA Pleasanton Fax: 925-225-9520
UHA Castro Valley Fax: 510-886-4532

Referring Provider Information:

Referred by (MD):_____ Medical Group: _____

Phone:____ -_____ -_____ Fax:_____-_____ -_____

Address:_____ City:_____ Zip:_____

Primary Care Physician: _____ PCP Phone: _____-_____-_____

This form completed By:_____ Phone: ____-____-_____

Patient Information *(Please provide copy of patient demographics/face sheet)*:

Last Name:_____ First Name:_____ MI:_____

DOB:____/_____/____ Gender: Male / Female Phone:____-____-_____ Ht:_____ Wt:_____

Patient's Address:_____

City/State/Zip:_____ Needs Interpreter? Y / N Language:_____

Special Assistance? _____

Reason for Referral:

Diagnosis/ICD10:_____ Service /Specialty Requested:_____

Physician Requested:_____

Current Insurer: _____ Authorization Required? Y / N

Type of Service Requested:

Type of Visit:
☐ Clinic Consultation ☐2nd Opinion ☐Follow-up ☐Surgery ☐Clinical Trials ☐Tumor Board

All Relevant Documentation to Support Diagnosis *(Please fax with this form)*:

- Tumor Board
- Clinical Trials
- Genetic / Molecular Testing
- Lab Reports
- Imaging Report
- Chemotherapy Treatment Records
- Pathology (biopsy results)
- Radiation Oncology Results
- Operative Reports for Cancer Surgery