COMMUNITY HEALTH PLAN of Washington™

DIALYSIS NOTIFICATION FORM

NOTE to Provider: *Please provide the information requested and fax the completed form to:* ***CHPW Case Management Referral Fax: 206-652-7073***		
Patient Information		
Last Name: (Print)	**First Name**: (Print)	**DOB**:
Member ID #:	**Line of Business**: ☐ Medicare Advantage ☐ Apple Health	**For Apple Health Patients only**: Medicare application completed? ☐ Yes ☐ No
Diagnosis:	**Date initial diagnosis made**:	**Initial Dialysis start date**:
Is the patient currently inpatient? ☐ Yes ☐ No	**Facility Name**:	**Facility location (**City, State):
Requesting Provider Information		
Provider Name: (Print)	Address:	Phone:
☐ Participating ☐ Non-Par	Contact Name:	Contact direct phone #:
Treating Provider Information		
Dialysis Center Name:	Address:	Phone:
Form completed by:		
Name: (Print)	Title:	Phone: