COMMUNITY HEALTH PLAN of Washington™

DISEASE MANAGEMENT REFERRAL FORM

To request Disease Management services, please complete the information below and Fax this form to (206) 652-7073

☐ Urgent (within 1 business day)
☐ Routine (within 5 business days)

PATIENT INFORMATION

Last Name: _____

First Name: _____

Member ID: _____

Date of Birth: _____

(If member is under age 14, Parent or Guardian First and Last Name): _____

Primary Contact No: _____

☐ ☐ ☐ ☐ ☐

City: _____

HEALTH CARE TEAM INFORMATION

Referral Date: _____

Referred by: _____

Phone No: _____

PCP: _____

Phone No(s): _____

Fax No(s): _____

1. Reason for referral: _____
2. Diagnosis: _____
3. History of present condition: _____

   Current services (if known): _____

Comments: _____

COMMUNITY HEALTH PLAN of Washington

Committed to your health.

SUBMITTING A DISEASE MANAGEMENT REFERRAL:

Please fax this referral form, and any additional clinical information that may assist the Disease Case Manager in providing services to your patient, to Community Health Plan at **(206) 652-7073**.

DISEASE MANAGEMENT – GENERAL INFORMATION:

CHP provides Disease Case Management (DM) services for patients who:

1. Have diabetes
2. Have asthma
3. Have congestive heart failure (CHF)
4. Have chronic obstructive pulmonary disease (COPD)
5. Have depression

Upon referral, the Disease Management department will assess the patient's needs and communicate with the appropriate providers of care. Based on need, pertinent supportive or educational interventions will be implemented in conjunction with the providers of care.