



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: <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Apple Health	For Apple Health Patients only: Medicare application completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:	Date initial diagnosis made:	Initial Dialysis start date:
Is the patient currently inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility Name:	Facility location (City, State):
Requesting Provider Information		
Provider Name: (Print)	Address:	Phone:
<input type="checkbox"/> Participating <input type="checkbox"/> Non-Par	Contact Name:	Contact direct phone #:
Treating Provider Information		
Dialysis Center Name:	Address:	Phone:
Form completed by:		
Name: (Print)	Title:	Phone:

