Dialysis Notification Form

COMMUNITY HEALTH PLAN of Washington™ APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE COMMUNITY HEALTH NETWORK of Washington™ CASCADE SELECT	**Fax Form to: 206-652-7067** **Medicaid 1-800-440-1561** **Medicare 1-800-942-0247** **CHNW Cascade Select 1-866-907-1906**	**PLEASE TYPE or WRITE LEGIBLY** or request will be returned as unable to process

NOTE to Provider: *Please provide the information requested and fax the completed form to:*
Case Management Referral Fax: 206-652-7092

Last Name: (Print)	**First Name**: (Print)	**DOB**:
Member ID #:	**Line of Business**: ☐ Medicare Advantage ☐ Apple Health IMC ☐ CHNW - Cascade Select	**For Apple Health and Cascade Select 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: