# Dialysis Notification Form

COMMUNITY HEALTH PLAN of Washington™
The power of community

**Fax Form to: 206-652-7067**
**Medicaid 1-800-440-1561**
**Medicare 1-800-942-0247**
**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**:<br>☐ Medicare Advantage<br>☐ Apple Health IMC<br>☐ CHNW - Cascade Select | **For Apple Health and Cascade Select Patients only**:<br>Medicare application completed?<br>☐ Yes ☐ No |
| **Diagnosis**: | **Date initial diagnosis made**: | **Initial Dialysis start date**: |
| **Is the patient currently inpatient?**<br>☐ 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: |