



**DISEASE MANAGEMENT REFERRAL FORM**

To request Disease Management services, please complete the information below and  
Fax this form to (206) 652-7073  
(for internal referrals, please submit to Case Management Care Specialist)

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

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Person ID (if unknown, Member No.) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Primary Contact No: \_\_\_\_\_

LOB:                     BHP     HO     SCHIP     MA     GAU

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: \_\_\_\_\_

**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) 613-8873**. For internal referrals, please submit to the Disease Management Assistant.

**DISEASE MANAGEMENT – GENERAL INFORMATION:**

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

1. Have diabetes
2. Have asthma

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.