Inpatient Admission Form

COMMUNITY HEALTH PLAN of Washington™
The power of community

Community HealthFirst™
Medicare Advantage Plans

For Apple Health/Medicaid:
Fax: (206) 652-7078
Notification is required by next business day

Please call Customer Service to verify eligibility & benefits:
1-800-440-1561
Monday through Friday, 8a.m. – 5p.m.

For Medicare Advantage Plans:
Fax: (206) 652-7065
Notification is required within 24 hours

Please call Customer Service to verify eligibility & benefits:
1-800-942-0247
7 days a week, 8a.m. - 8p.m.

Inpatient Admission notification may be made through the Medical Management Portal at www.chpw.org/submitcare

FACILITY INFORMATION

Hospital Name:	Contact Name:	Today's Date:
Phone #:	Fax #:	Tax ID:

PATIENT INFORMATION

First Name:	Last Name:	MI:	Date of Birth

CHPW Member ID:	Plan/Program:	☐ Patient Retro Enrolled with CHPW	Retro Enrolled Date:

ADMISSION INFORMATION

Admit Date:	Admit Time:	Admit Type:	Discharge Date:
		☐ Planned (Routine) ☐ Urgent (Direct Admit or Transfer) ☐ Emergent (Through ED)	

Admitting Physician:	Admitting Diagnosis:

NEWBORN INFORMATION *(Only to be completed for OB admissions, infants require their own notification)*

Sex:	Date of Birth	First Name:	Last Name:	MI:

Delivery Type: ☐ Vaginal ☐ C-Section	Bed Type: ☐ Regular Nursery ☐ Special Care Nursery/NICU	Attending Pediatrician:

A Notification is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service