

Inpatient Admission Form



COMMUNITY HEALTH PLAN
of Washington™

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:
CHPW Member ID:	Plan/Program:	<input type="checkbox"/> Patient Retro Enrolled with CHPW		Retro Enrolled Date:
ADMISSION INFORMATION				
Admit Date:	Admit Time:	Please indicate clinical urgency of request: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent		Discharge Date:
Admitting Physician:		Admitting Diagnosis:		
NEWBORN INFORMATION <i>(Only to be completed for OB admissions, infants require their own notification)</i>				
Sex:	Date of Birth:	First Name:	Last Name:	MI:
Delivery Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	Bed Type: <input type="checkbox"/> Regular Nursery <input type="checkbox"/> 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