



Provider Specialist Access Assistance Form

Please provide the information below (person/clinic) completing the form:

First Name:	<input type="text"/>	Last Name:	<input type="text"/>
Clinic:	<input type="text"/>	Tax ID:	<input type="text"/>
Email:	<input type="text"/>	Phone:	<input type="text"/>
Address:	<input type="text"/>		
Suite:	<input type="text"/>	City:	<input type="text"/>
Zip:	<input type="text"/>	County:	<input type="text"/>

List the type of Specialist(s) you are unable to access, i.e., Orthopedics, Neurologist, etc.:

1.	<input type="text"/>	3.	<input type="text"/>
2.	<input type="text"/>	4.	<input type="text"/>

To better serve you--use the text box below and briefly describe your challenges with each of the specialists listed above. For example, you may include:

- Names of clinics and providers contracted with CHPW who no longer accept **new** referrals for CHPW members.
- Names of clinics and providers who appear not to meet reasonable timelines for appointments, i.e., new patient appointments, established appointments, etc.
- List non-participating clinics and providers you regularly refer to who no longer accept referrals for CHPW members.
- List the reasons you believe are causing specialist referral challenges.

Please submit completed form:

Email: Provider.Relations@chpw.org *or*

Fax: 206 521-8837