Inpatient Admission Form

COMMUNITY HEALTH PLAN of Washington™
The power of community

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, 8 a.m.-5 p.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, 8 a.m. - 8 p.m.

Inpatient Admission notification may be made through the Medical Management Portal at 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:	Discharge Date:		
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