CUSTOMER SERVICE: 1-800-440-1561
FAX: 206-652-7085
EMAIL: EligibilityDept@chpw.org
ATTN: ELIGIBILITY COORDINATOR

CLINIC ASSIGNMENT SELECTION FORM

All changes are effective the first day of the month following the date of this request.

☐ Integrated Managed Care ☐ Medicare/SNP ☐ Cascade Select

From Clinic ____

To Clinic ____ Location _____________

	MEMBER LAST NAME	MEMBER FIRST NAME	DOB	CHP ID
1	____________________	____________________	__________	_____________
2	____________________	____________________	__________	_____________
3	____________________	____________________	__________	_____________
4	____________________	____________________	__________	_____________
5	____________________	____________________	__________	_____________

Member signature _______________________________________ **Date** __________

FOR NEWBORNS ONLY

(For correct assignment, Community Health Plan must receive form within 15 days of birth.)

Newborn's name ____
Last First Middle

Date of birth ___________________________ Sex _______________

Newborn's requested Clinic ____

Mother's full name ____
Last First Middle

Mother's Community Health Plan # ________________ Mother's Provider One # __________________

Mother's assigned Clinic ____

Mother's signature __________________________________ **Date** ______________

Form completed by clinic or customer service representative:

____ Phone ______________

This form supplies Community Health Plan with the information needed to assign a newborn to the correct clinic and to correctly assign member information to the newborn. Incorrect information may result in an incorrect clinic assignment or duplicate newborn records. If Community Health Plan does not receive a newborn clinic selection form within 15 days of birth, the newborn will be assigned to the mother's clinic (if applicable). If this form is not received and the newborn sees a doctor who is not the newborn's assigned PCP, the PCP does not have to authorize the visit.

Version date: 04/14/2026