PLEASE FILL OUT & RETURN THIS FORM WITH PAYMENT

APPLICATION FEE FOR PATIENT DECISION AID CERTIFICATION REVIEW

There is a required application fee to support costs for the certification review process.

Please send a check in the amount of $3000, along with this completed form to the following address:

Washington Health Care Authority
Patient Decision Aid Certification
PO Box 42691
Olympia, WA 98504-2691

Please provide the following information to ensure a timely reimbursement, if necessary:

Name of organization:____

Mailing address:____

____

Point of contact:____

Email:____

Telephone:____

Title of Patient Decision Aid(s):____

____

Check #___________

For HCA Use Only:

Accounting: For deposit to CQCT Patient Decision Aid Certification program

Internal contact information for questions – Sarah Pearson, CQCT Division – 5-0877, sarah.pearson@hca.wa.gov.