Washington State Health Care Authority

Patient Review and Coordination Referral Form

DATE

NOTE: If you wish to remain anonymous, do not provide your name as it may be subject to public disclosure. If you choose not to remain anonymous, please provide your name and phone number so one of our investigators may contact you if any additional information is needed.

This form will be used for referring medical assistance clients who are in fee for service or managed care. If client is on managed care, the referral will be forwarded to the managed care plan.

REFERRAL SOURCE			
CONTACT NAME	BUSINESS ORGANIZATION	TELEPHONE NUMBER	FAX NUMBER

CLIENT NAME			
LAST NAME	FIRST NAME	MI	DOB

P1 ID NUMBER	ADDRESS	CITY	STATE	ZIP CODE

REASON FOR REFERRAL

If you are a provider, are you willing to be this client's primary care provider (PCP), primary pharmacy, or hospital? If yes, please provide us with your name and phone number.

*Note: Please complete the form as much as possible. Send the form by encrypted email or by fax, or mail.

E-MAIL: PRR@hca.wa.gov

WEBSITE: http://www.hca.wa.gov/medicaid/prr/Pages/index.aspx

PHONE: 1-800-562-3022 Ext 51606

FAX: (360) 725-1969

MAIL TO: Patient Review and Coordination Program
PO Box 45503
Olympia, WA 98504-5503