CMS REGION 10-SEATTLE

DIVISION OF FINANCIAL MANAGEMENT & FEE FOR SERVICE REFERRAL FORM

Fax: 503-947-7092 Telephone: 800-722-4134

Urgent ___________

INQUIRY SOURCE INFORMATION (If not beneficiary)

NAME: ____________________ DATE: ____________

TELEPHONE: ____________________ FAX: ____________

ORGANIZATION: ____________________ RELATION TO BENEFICIARY: ____________

BENEFICIARY OR PROVIDER INFORMATION

NAME: ____________ MEDICARE #: ____________________

DATE OF BIRTH: ______________________

TELEPHONE: ____________ CELL PHONE: ____________________

ADDRESS: ____________ CITY/ST/ZIP: ____________________

ISSUE TYPE (CHECK ALL THAT APPLY):

MEDICARE: Part A ☐ Part B ☐ Part C ☐ Part D ☐

Language (if other than English): ____

PRESENTING ISSUES/PROBLEMS:

ACTIONS TAKEN BY REFERRANT/BENEFICIARY/CAREGIVER, ETC.

PHARMACY (CONTACT) INFORMATION (If applicable)

PHARMACY: ______________________ **CONTACT:** ____________________

TELEPHONE: ______________________