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 ☐

Language (if other than English): _____

PRESENTING ISSUES/PROBLEMS:

ACTIONS TAKEN BY REFERRANT/BENEFICIARY/CAREGIVER, ETC.

PHARMACY (CONTACT) INFORMATION (If applicable)

PHARMACY: _____ **CONTACT:** _____

TELEPHONE: _____