If you would like to submit notifications online, you can visit www.chc-care.com, call the Care Coordinators at 800-247-8956 or fax to 800-973-2321

Helping physicians. Helping patients.

NOTIFICATION FORM

PATIENT INFORMATION	
Patient Name:	Employer Name:
Patient Date of Birth:	Cardholder ID No.:

REQUESTING PHYSICIAN INFORMATION	
Physician Name:	Physician Phone Number: Physician Fax Number: ATTN: ______________________________
Name of Person Completing Request:	Date of Request:

REFERRAL INFORMATION *OR*	PRE-NOTIFICATION INFORMATION Please submit any historical/clinical information that supports the need for the requested services
Specialist Name: Specialist Phone Number: Specialist Fax Number:	Provider/Facility Name: Provider/Facility Address: Provider/Facility Phone: Provider/Facility Fax:
Appointment Date if known:	Projected Date of Procedure:
Diagnosis Description/ICD9 Code:	Diagnosis Description/ICD9 Code
Scope of Referral: ☐ Normal 3 visits or 6 months ☐ Other:- # of Visits:_____ or # of Months:______. ☐ Evaluation Only ☐ Annual Follow-up (1 visit) ☐ Other Specify:	Procedure Requested/CPT-4 Codes: ____ Place of Service: ☐ Inpatient ☐ Outpatient ☐ Clinic/Office ☐ DME

Fax Request To:
800-973-2321

Updated January 2006