

CMS REGION 10-SEATTLE

DIVISION OF FINANCIAL MANAGEMENT & FEE FOR SERVICE REFERRAL FORM

Fax: 443-380-5377 (beneficiary/provider inquiries)

Telephone: 206-615-2399 (beneficiary inquiries only)

INQUIRY SOURCE INFORMATION (If not beneficiary)

NAME: _____ DATE:

ORGANIZATION: _____

TELEPHONE: _____ RELATION TO BENEFICIARY: _____

BENEFICIARY OR PROVIDER INFORMATION

NAME: _____ MEDICARE #: _____

TELEPHONE: _____ CELL PHONE: _____

CITY: _____ STATE/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: _____