COMMUNITY HEALTH PLAN of Washington™
Committed to your health.℠

CUSTOMER SERVICE: 1-800-440-1561
FAX: 206-652-7085
EMAIL: EligibilityDept@chpw.org
ATTN: ELIGIBILITY COORDINATOR

CLINIC ASSIGNMENT SELECTION FORM

All changes are effective the first day of the month following the date of this request.

☐ Integrated Managed Care ☐ Medicare/SNP ☐ Cascade Select

From Clinic _____

To Clinic _____ Location _____

	MEMBER LAST NAME	MEMBER FIRST NAME	DOB	CHP ID
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____

Member signature _____ **Date** _____

FOR NEWBORNS ONLY

(For correct assignment, Community Health Plan must receive form within 15 days of birth.)

Newborn's name _____
Last First Middle

Date of birth _____ Sex _____

Newborn's requested Clinic _____

Mother's full name _____
Last First Middle

Mother's Community Health Plan # _____

Mother's Provider One # _____

Mother's assigned Clinic _____

Mother's signature _____ **Date** _____

Form completed by clinic or customer service representative:

_____ Phone _____

This form supplies Community Health Plan with the information needed to assign a newborn to the correct clinic and to correctly assign member information to the newborn. Incorrect information may result in an incorrect clinic assignment or duplicate newborn records. If Community Health Plan does not receive a newborn clinic selection form within 15 days of birth, the newborn will be assigned to the mother's clinic (if applicable). If this form is not received and the newborn sees a doctor who is not the newborn's assigned PCP, the PCP does not have to authorize the visit.

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