CHIP PH-95 Referral Coversheet

TO: DHS/OIM/CENTRAL UNIT FAX: [717] 346-0363 DATE: _____

FROM: _____ ORGANIZATION: _____

TELPHONE: _____ ORGANIZATION FAX: _____

PID PROVIDER NO: P1712002 CHIP CONTRACTOR
MA PROVIDER NO.: _____

COMMENTS: _____

_____

Child's Name:	
Parent or Guardian:	
Address:	
County:	
UCI:	Date Family Notified:
Primary DX:	
Secondary DX:	
Physician/Practice - name/telephone/address/NPI	
Other Key Provider - names/telephone/address/NPIs	

FOR DPW USE ONLY

Approved: ☐	Effective Date: _____ Category: _____
Disapproved: ☐	Reason: _____
Caseworker/Date: _____	