CHIP PH-95 REFERRAL COVER SHEET

TO: DHS/OIM/CENTRAL UNIT **FAX:** (717) 346-0363 **DATE:** _____

FROM: _____ **ORGANIZATION:** _____

TELEPHONE: _____ **ORGANIZATION FAX:** _____

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

COMMENTS: Enter comments

CHILD'S NAME:	DATE OF BIRTH	PARENT OR GUARDIAN:
ADDRESS:		
COUNTY:	UCI:	DATE FAMILY NOTIFIED:
PRIMARY DX:		
SECONDARY DX:		
PHYSICIAN/PRACTICE - NAME/TELEPHONE/ADDRESS/NPI:		
OTHER KEY PROVIDER(S) - NAME/TELEPHONE/ADDRESS/NPI:		

FOR DHS USE ONLY

Approved: ☐ Effective Date: _____ Category: _____

Denied: ☐ Reason: _____

Caseworker/Date: _____

CONFIDENTIAL: This content (including any attachments) contains confidential information intended for a specific individual and purpose, and is protected by law.