

**Patient intake form required for new Medicaid patients.**

Fax: (360) 343-0513

Attn: Billing

From: \_\_\_\_\_

7 digit provider ID: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

City/Zip: \_\_\_\_\_

Patient date of birth: \_\_\_\_\_

Patient gender: \_\_\_\_\_

Patient 12 digit Medicaid number: \_\_\_\_\_

Patient diagnosis: \_\_\_\_\_

***For claims requiring prior authorization, the following information is required:***

Prior auth: \_\_\_\_\_

Billing code: \_\_\_\_\_

Delivery/completion date: \_\_\_\_\_

Billed amount: \_\_\_\_\_

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