Revised April 2025

Comagine Health

CASE MANAGEMENT REFERRAL FORM

Patient Name _____

Patient SSN _____

Address _____

City _____ State _____

Zip _____ DOB _____

Phone (W) _____ (H) _____

Subscriber Name _____

Subscriber Number _____-_____-_____

Plan _____

Date of Referral _____

Contact _____

Phone _____

Primary Diagnosis _____

Secondary Diagnosis _____

Current issues _____

_____

Primary Care Physician _____

Phone _____

Physician Specialist if applicable _____

Specialty _____ Phone _____

Reason for referral _____

_____

_____

Expectations _____

_____

Other _____

_____

P.O. Box 33400 Seattle, WA 98133-0400

Phone: (888) 578-2547 **Alaska Review FAX (877) 265-9549**