TualityHealthAlliance

THA ENCC REQUEST FORM

PRINT AND FAX

Date of Request: _____/_____/_____

Fax: 503-681-1823

Tuality Health Alliance (Please check appropriate action plan)

☐ **Access** ☐ **Community Support** ☐ **Care Coordination** ☐ **Medical Services**

****PLEASE INCLUDE ANY NOTES****

Contact Name: **Requestor e-mail:** **Primary Care Physician:** **Phone Number:**		
Patient Name : **Patient Phone Number:**	**ID Number:**	**Date of Birth:**
Care Management Concerns/Notes:		
*Diagnosis_____ ICD-10 _____		
Referral Received Date_____ Member Contact Date _____		
************THA INTERNAL USE ONLY**************		
Assigned to: Care Management_____ Date_____ Community Outreach Specialist_____ Date_____		