

Whatcom Project Access Enrollment Referral Form



The following patient is a possible candidate for enrollment in *Whatcom Project Access*:

Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Second Phone: _____

Primary Care Physician/Provider of record: _____

Referring Practitioner (if different from above): _____

Office Contact Person: _____

Patient needs referral to (type of specialty): _____

Please provide a brief description of the referring diagnosis / medical reason for enrollment in Project Access*.

* Because patients must be screened first, **WPA is unable to accept urgent referrals**. Please call if you have questions.

I believe this patient may be eligible for Project Access because he/she is not insured through private health insurance, is not on Medicaid or Medicare, and is low income. I understand that insured patients are not eligible for Project Access, even if their insurance does not cover medications.

Physician/Provider Signature

Date

Please fax this form to *Whatcom Project Access*. We will contact the patient to determine if they qualify for other insurance or Project Access, and notify your office of the outcome. If the patient is eligible, we will contact your office with the name of the WPA specialty provider and ask you to fax chart notes directly to their office.