Cascade Health Alliance, LLC

Oregon Mobile Healthcare Referral

Date of referral: _____

Referring Facility: _____

Referring Provider: _____ **Phone #:** _____

Member Name: _____ **PCP:** _____

Member ID #: _____ **D.O.B.** _____

Primary Reason for Referral

Additional Comments

Please fax this form or call CHA Case Management to refer a member to Oregon Mobile Healthcare.

2909 Daggett Ave, Suite 225 ● Klamath Falls, OR 97601 ● 541-883-2947 ● Fax: 541-882-6914