CVAB Peer Bridger Referral – Southwest WA

(Please use this form only for referrals in community inpatient settings)

Please complete 1 or 2 depending on referring agency and as much of 3 & 4 as possible. Thank you.

CVAB
COMMUNITY VOICES ARE BORN

1. Referring MCO or BH-ASO Information	
a. MCO or BH-ASO liaison name:	**c. Phone:**
b. MCO that member is assigned to (or Beacon):	**d. Email:**
2. Referring Inpatient Facility Information	
a. Facility staff making referral name:	**c. Phone:**
b. Facility:	**d. Email:**
3. Person being Referred Information	
a. Name of Individual:	**b. DOB (needed for claims system)**
c. Contact Info/Phone	
d. Address	
e. Diagnosis Code (ICD10)	**f. Provider 1 ID**
g. Is the individual currently hospitalized/inpatient? Yes ☐ No ☐	**h. If yes, discharge date & name of facility:**
4. Reason for referral to Peer Bridger program	

Please send secure email (berryb@cvab.org) or fax (360.397.8059) completed form to CVAB.