



Patient Referral Form

Extended Care Health Option (ECHO) & Autism Demonstration Project

To refer a patient to either the ECHO program or the Autism Demonstration Project, please fax this completed form to **(866) 269-5758**. Please include any additional information that may assist TriWest in providing services to your patient. If you have questions about these programs, please call 1-888-TRIWEST (874-9378) or visit www.triwest.com.

The type of referral being made (choose only **one**):

- ECHO** **Autism Demonstration Project**

Patient Information (please print)		
Last Name:	First Name:	
Patient's Date of Birth: / /	Sponsor's SSN:	
Home Address:		
Home Phone:	Cell Phone:	Work Phone:

Referral Source Information (please print)	
Name of Person Completing Form	Phone:
Patient's Primary Physician:	
Phone:	Fax:
Specialist(s) Involved in Care:	
Phone:	Fax:

Reason for Referral (please print)

Please fax completed form to:
 TriWest Healthcare Alliance - ECHO Coordinator
1-866-269-5758

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or healthcare operations including medical records requested for the provision of healthcare services. Privacy Act Statement – This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations of this may be punishable by fines, imprisonment, or both.