KAISER PERMANENTE®

Patient information

Patient name:________________________________ Kaiser Permanente member number:_______________________________

Patient date of birth: _________________________Today's date:____

Delivery method / recipient

☐ In person pick up ☐ Self ☐ 3rd party:______________________________ Contact Ph. Number:____________

☐ By fax: Attention:_______________________________________
Fax#:____

☐ Mail: ☐ Self ☐ 3rd Party Mail to: ____
Address: ____
City: ________________State: __________Zip: ________________

About the patient's condition

Name of Kaiser Permanente clinician seeing the patient:____

Clinic where patient is seen for this condition:____

Brief description of the condition, injury, or diagnosis:____

Was the patient in the hospital? ☐ No ☐ Yes (if yes, what dates?) ____

Request type

What type of request is this? ____

What is the form name:____

Description of the form:____

Are you requesting an accommodation? ☐ No ☐ Yes (if yes, what type of accommodation?) ____________________

____

Is this an FMLA / WA PFML request? *If* ***YES****, please see "Front desk staff" for the FMLA/WA PFML intake form.*
Do not use this form for FMLA/WA PFML requests.

Forms Processing Acknowledgment

- This acknowledgment must be signed by the patient, parent, legal guardian, or person with legal power of attorney prior to the completed form being picked up, mailed, or faxed.
- Kaiser Permanente Washington requires up to **fifteen (15) calendar days** for processing all forms.
- This form complies with 45 CFR 164.524 (c) 3 (also known as HITECH Act)

I have read, understand, and agree to the above forms processing acknowledgment statements.

____ __________
Signature of patient, parent, legal guardian, or person with legal power of attorney Date