## FAX-TO-QUIT REFERRAL FORM

Date



Use this form to refer patients who are ready to quit tobacco in the next 30 days to the Colorado QuitLine.

PROVIDER(S): Complete this section	
Provider name	Contact name
Clinic/Hosp/Dept	E-mail
Address	Phone ( ) –
City/State/Zip	Fax ( ) –
<b>PLEASE INDICATE IF THE PATIENT HAS MEDICAID:</b> YES NO If yes, and you are prescribing tobacco cessation medication, please cor form and provide patient with a prescription. All FDA-approved tobacco	
Does patient have any of the following conditions?	ase
$\Box$ YES, I authorize the QuitLine to send the patient over-the-counter nic	nicotine replacement therapy.
Provider signature	
A provider signature is required to authorize the QuitLine to dispense ni of the above conditions.	nicotine replacement therapy for patients with any
Comments	

## **PATIENT: Complete this section**

Yes, I am ready to quit and ask that a QuitLine coach call me. I understand that the Colorado QuitLine will inform my provider about my participation.

Best times to call?	Insurance? Yes No Insurance carrier: Member ID: Medicaid? Yes No						
Date of birth: / / Gender $\Box M \Box F$							
Patient name (Last) (First)							
Address	City CO						
Zip code	E-mail						
Phone #1 ( ) –	Phone #2 ( ) –						
Language 🗆 English 🔲 Spanish 🖾 Other							
Patient signature	Date						

## PLEASE FAX THIS PATIENT FAX REFERRAL FORM TO: 1-800-261-6259

Or mail to: Colorado QuitLine, National Jewish Health, 1400 Jackson St., M305, Denver, CO 80206

**Confidentiality Notice:** This facsimile contains confidential information. If you have received this in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy or distribute.

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Requests that do not include the required information will experience a delay in the approval process. To expedite this process, please review the prior authorization criteria in Appendix P at <a href="http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132">http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132</a>. Date

Signature of Prescriber\_

By signature, the Prescriber confirms the criteria information above is accurate and verifiable in patient records

FAX TO:	COLORADO Medicaid Prior Authorizations	
	Fax: (888)-772-9696	
	PA HELPDESK: (800) 365 - 4944	

Revised	08/2009

