

## **CHNCT DONOR REQUEST FORM**

Member's Name: \_\_\_\_\_ Member's DOB: \_\_\_\_\_

Member's ID #:           Plan: Husky \_\_\_\_\_ Charter Oak \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Name of procedure: \_\_\_\_\_ Name of Contact: \_\_\_\_\_

Procedure Code: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

**Please include the following information with your request:**

- Clinical Notes
- Date of Procedure

**Clinical notes must be faxed to CHNCT for review**  
**Please fax request to 203-265-3994. Thank You**

**\*\*PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF  
ALL CLINICAL INFORMATION TO PROCESS REQUEST\*\***