COMMUNITY FIRST
HEALTH PLANS

MEMBER EDUCATION REQUEST FORM

Provider Name: Provider Phone Number:

Contact Person:

Member Name: Member Phone Number:

Member ID: HMO Medicaid CHIP ASO Health Exchange

Type of Education Requested

(Check appropriate box and provide a brief description on requested education)

Appointment no-shows *(Must have at least three no-shows, please include dates)*

1st Date: 2nd Date: 3rd Date:

Referral Process

Newborn

Abusive with doctor and/or staff

Non-compliance with medical treatment

Paper copy of the Clinical Practice Guidelines or updates

Disease Management Programs *(Please specify program)*

Asthma Diabetes Prenatal Behavioral Health

Care Management *(Please specify)*

Medical Behavioral Health

Other *(Describe)*

Please fax to Network Management at (210) 358-6199

FOR INTERNAL USE ONLY

Referred to: Health Services Management Member Services

Completed by: Date Completed:

Please return to Network Management upon completion. 08/28/2015