COMMUNITY FIRST HEALTH PLANS

# MEMBER EDUCATION REQUEST FORM

Provider Name : _____

Provider Phone Number : _____

Contact Person : _____

Member Name : _____

Member ID : _____

Member Phone Number : _____

- ❑ 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)

Dates: _____

❑ Referral process

❑ Non-compliance with medical treatment

❑ Newborn

❑ Abusive with doctor and/or staff

❑ Disease Management Programs (please specify program: Asthma, Diabetes, Prenatal, Behavioral Health)

❑ Care Management (please specify: Medical, Behavioral Health)

❑ Paper copy of the Clinical Practice Guidelines or updates

❑ Other

Description: _____

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

## FOR INTERNAL USE ONLY

Referred to : ❑ Health Services Management ❑ Member Services

Completed by : _____ (Please print)

Date Completed : _____

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