



COMMUNITY FIRST HEALTH PLANS

MEMBER EDUCATION REQUEST FORM

Provider Name : _____

Provider Phone Number : _____

Contact Person : _____

Member Name : _____

HMO

Member ID : _____

Medicaid

Member Phone Number : _____

CHIP

ASO

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)
- Referral Process
- Newborn
- Disease / Population Management Programs (please specify program: Asthma, Diabetes, Prenatal, End Stage Renal)
- Other
- Non-compliance with medical treatment
- Abusive with doctor and/or staff

Description: _____

Please fax back 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