



**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**

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Referred to :  Health Services Management  Member Services

Completed by : \_\_\_\_\_ (Please print)

Date Completed : \_\_\_\_\_

Please return to Network Management upon completion.