COMMUNITY FIRST HEALTH PLANS

EXHIBIT 11

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