COMMUNITY FIRST HEALTH PLANS

Member Education Request Form

Providers are encouraged to inform Members about the health education services available through Community First. When an education or social need is identified, one can refer a Member to the Preventive Health and Disease Management Department.

Provider Name: _____ Provider Phone Number: _____

Contact Person: _____

Member Name: _____ Member Phone Number: _____

Member ID: _____

☐ Commercial HMO ☐ Medicare Advantage D-SNP ☐ CHIP/CHIP Perinate ☐ University Family Care Plan

☐ Medicaid ☐ Medicare Advantage ☐ Marketplace (University Community Care Plan)

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 ☐ Behavioral Health

☐ Prenatal ☐ Hypertension ☐ Lifestyle Management

☐ 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.