COMMUNITY FIRST
HEALTH PLANS

Provider Request for Member Transfer Form

Providers can use this form to request the transfer of a Community First Member.

REQUESTER INFORMATION

Physician Name: _____ Date of Request: _____

Office Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

I am proposing a transfer of care of the Member identified in this form. The request for transfer is substantiated by the information explained below.

I am aware that processing and evaluating a request for transfer entails a minimum of ten (10) working days from the date of receipt of completed transfer request form, which requires supporting documentation. Until the effective date of transfer, the Member's care remains the responsibility of the assigned Primary Care Provider/Health Center.

MEMBER INFORMATION

First Name: _____ Last Name: _____

ID Number: _____ DOB: _____ Phone: _____

Health Plan: ☐ STAR Medicaid ☐ STAR Kids ☐ STAR+PLUS ☐ CHIP ☐ HMO ☐ University Family Care Plan ☐ Medicare

Justification for the proposal to transfer this Member is as follows (check all that apply):

☐ No-Shows ☐ Non-Compliance with medical treatment ☐ Abusive with doctor and/or staff

Other: _____

Include details and sequence of events. Cite specifics as to frequency and type of disruptive behaviors by Member. You must have at least three (3) no-shows to transfer a Member and must include dates.

Provide summary of efforts including a history of prior attempts to resolve the problem, dates of attempts, and names of witnesses.

Explain other options offered to Member prior to consideration of transfer (optional).

Please fax completed form to Network Management at (210) 358-6199 or email to NMCFHP@cfhp.com