

Member Education Request Form

Please complete this form and return via fax or mail to Neighborhood Customer Service. Address information above.

Date: _____ Number of pages (including this cover sheet): _____

Provider Group Name: _____ Site Liaison/Contact Name: _____

Phone Number: _____ Fax Number: _____

Member Information:

Member Name: _____ Member ID # or SSN#: _____
Nombre Numero de Inditificacion'

Parent/Head of Household Name: _____ Member ID # or SSN#: _____
Nombre del Pariente o Guardian Numero de Inditificacion

Phone Number: _____ Best time to reach: _____
Telefono Mejor tiempo apropiado para llamar

Education Request: Please check the type(s) of education to be provided:

_____ Referral process (specify): _____

_____ Proper use of the ER, Specialty Practitioners (specify): _____

_____ Frequently misses appointments (please list DOS): _____

_____ Benefit education (specify Dental, Pharmacy, Transportation, Vision, Substance Abuse, Mental Health, OB/GYN): _____

_____ Follow-up care overdue (request that member contacts Neighborhood to schedule an appointment - please specify): _____

_____ Other education (please describe): _____

Additional Comments – Please provide additional comments in the space below as needed:

For Neighborhood Use Only:

Resolution: _____

Completed by: _____ Date Completed: _____