Member Education Form

TO: **Molina Member Services Department** FAX: **(425) 424-1163 or (800) 816-3778**

From: ______________________ (Doctor/Clinic): ______________________

Date: ____________ Phone: ______________ Fax Number: ______________

This form can be used when a Molina Healthcare member requires education from the Molina Member Services Department. Please provide all the requested information, or the form may be returned to your office.

Patient Name: ______________________

Parent/Guardian Name (if patient is under 18): ______________________

Patient Phone Number: ______________________

Patient Address: ______________________

Molina ID Number: ______________________

Please contact this patient or parent/guardian regarding the following:

- ☐ Repeated Missed/Late Appointments
- ☐ Inappropriate Requests for Urgent Referrals
- ☐ Benefit Explanation
- ☐ Authorization Procedure Explanation
- ☐ Inappropriate Emergency Room Usage
- ☐ Disruptive Behavior/Non-Compliance
- ☐ Self-Referral
- ☐ Other: ______________________

Please explain in-depth, including date of occurrence(s), if applicable:

____

____

____

____

____

MOLINA OFFICE USE ONLY

Member Services Representative Name/Date of Follow-up Call with Member: ______________________

____

Comments/Outcome: ______________________

____

____

Date Completed and Copy Sent to Provider’s Office: ______________________

MHW PART #1050-1904
MHW-5/10/2019
14076746WA0419