Exhibit 15

COMMUNITY FIRST HEALTH PLANS

MEMBER EDUCATION REQUEST FORM

Provider Name : _____

Provider Phone Number : _____

Contact Person : _____

Member Name : _____

Member ID : _____

Member Phone Number : _____

❑ HMO
❑ Medicaid
❑ CHIP
❑ ASO

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)
❑ Referral Process
❑ Newborn
❑ Non-compliance with medical treatment
❑ Abusive with doctor and/or staff
❑ Disease / Population Management Programs (please specify program: Asthma, Diabetes, Prenatal, End Stage Renal)
❑ Other

Description: _____

_____

_____

_____

_____

Please fax back to Network Management at (210) 358-6199

FOR INTERNAL USE ONLY

Referred to : ❑ Health Services Management ❑ Member Services

Completed by : _____ (Please print)
Date Completed : _____

Please return to Network Management upon completion