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: _____

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