MEMBER RE-EDUCATION FORM

The following member needs to be re-educated regarding:

☐ Their enrollment in the plan
☐ What the plan is
☐ How the plan works
☐ PCP selection
☐ Network Specialists
☐ Discount/Value Added services: Vision, Dental, Hearing Aid, Silver Sneakers

☐ Other: __________________________________________________________________________

Date: _____________________________________________________________________________

Patient Name: _____________________________________________________________________

Patient Phone Number: _____________________________________________________________

Physician Name / Provider #: _______________________________________________________

Physician Phone Number: __________________________________________________________

County / State Physician is located: _________________________________________________

PLEASE FAX FORM TO 256.881.8062

To Be Completed by HealthSpring:

OUTCOME: _________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Response To Physician Faxed on: _________________________________________________