Cook Children's Health Plan

Outreach Department
PO Box 2488
Fort Worth, TX 76113-2488
Fax 682-885-8436

Member Education Request Form

Provider Name _____

Provider Phone Number _____

Contact Person _____

Member Name _____

Member ID _____

Member Phone Number _____

TYPE OF EDUCATION REQUESTED

(Check appropriate box & provide a brief description on requested education)

- ☐ Appointment No-Shows (at least three no-shows, please include dates)
- ☐ Referral Process
- ☐ Newborn
- ☐ Disease Management Program (please specify Asthma, Diabetes, Prenatal, Obesity)
- ☐ Non-compliance with medical treatment
- ☐ Abusive with doctor and/or staff
- ☐ Medicaid/CHIP Renewal Assistance
- ☐ Other

Description:_____

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Please fax to CCHP OUTREACH 682-885-8436