BlueCross BlueShield of Texas

TEXAS STAR Your Health Plan ★ Your Choice | TEXAS Health and Human Services | CHIP | TEXAS Health and Human Services

Member Advocate Request Form

Purpose: Please complete this form to request that a Member Advocate contact a member. Please fax completed form to **1-512-349-4867.** If you need assistance completing this form, please contact your local Member Advocate at **1-877-375-9097.**

Date: _____

Provider Information

Practice Name: _____ Contact Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Patient Information

Patient Name: _____ Medicaid ID Number: _____

Patient Address:
(validate before visit) _____

Parent/Guardian Name: _____ Phone: _____

Reason for Outreach Request

☐ Noncompliant (Reason) _____

☐ Health Education Classes (list classes): _____

☐ New Member Benefits Orientation _____

☐ No-Show for appointment (list dates): _____

☐ Community Resources (list need): _____

CRC Outreach Notes (To be completed by Outreach Specialist.)

Outreach Specialist: _____ Phone Number: _____

Date of Home Visit: _____ Number of Family Members: _____

Patient has: ☐ STAR ☐ CHIP

Preferred Language: _____

Notes: _____

_____

_____

Date Faxed to Provider: _____

SCP-9109-17