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: ______________________________

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Date Faxed to Provider: ______________________________

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