



Member Education Request Form

Date: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member ID # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

PCP: Name \_\_\_\_\_ PCP ID # \_\_\_\_\_

Contact Person: \_\_\_\_\_

PCP Phone # \_\_\_\_\_ PCP Fax# \_\_\_\_\_

PCP County \_\_\_\_\_

Please educate the member on the following areas:

- Referral Use
- Inappropriate Use of Emergency Room
- Not showing up for appointments or follow-up care
- Complete review of the benefits of AmeriHealth Mercy Health Plan
- Other: \_\_\_\_\_

Additional Information/Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please fax this form to: **1-866-208-8145**

or mail to the following address

**AmeriHealth Mercy Health Plan**  
8040 Carlson Drive, Ste. 500  
Harrisburg, PA 17112

If you have questions, please call **1-877-693-8271**

**FOR OFFICE USE ONLY**

Follow-up performed: \_\_\_\_\_

Comments: \_\_\_\_\_