Member Intervention Form

Use this form to refer WellCare members to Member Outreach Coordinators for intervention.

Date: ___________________ *Member Name: ____

*WellCare Member Number or Social: ____________________________

*Member Address: ____

*Member Phone: ____________________________

Please check the reason for the referral:

____ Failure to follow doctor's instructions
____ Failure to keep appointments (**3 consecutive**)
____ Failure to maintain EPDST standard
____ Disruptive Behavior
____ Other (please state reason) ____

____

____

Provider Expectation: ____

____

____

*Provider Name: ________________________ *WCG Provider Relations Rep: _____________________
*Provider Address: ____
City: ___________________________________ Zip Code: ___________________

*Point of Contact: ____ *Telephone: ___________________

Please fax this form to 866-889-8202

Please circle your preferred method of response: email or phone

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Provider Response Form

Use this form to communicate the outcome to member intervention forms.

A WellCare Member Outreach Coordinator did attempt to reach out to the following member________________________________

Outcome:

- **Attempt to contact/unable to reach**
- **Member has changed primary care physician**
- **Invalid phone number**
- **Letter sent to member**
- **Educated member**

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