Member Intervention Form

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

Date: ___________________ *Member Name: ____

*WellCare Member ID or Medicaid ID: ____________________________

*Member Address: ____

*Member Telephone: ____________________________

Please check the reason for the referral:

____ Failure to follow doctor's instructions
____ Failure to keep appointments (3 consecutive)
____ Failure to maintain EPDST standard(s)
____ Disruptive Behavior
____ Member referral to ER (please state reason) ____
____ Other____
____
____
____

Provider Expectation:

____
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____
____
____

*Provider Name: ____

Provider Address: ____

City: __________________________________ Zip Code: ___________________

*Point of Contact: ____ *Telephone: ___________________

Please fax this form to the appropriate WellCare Regional office:

Albany	**229-883-4524**	**Columbus**	**706-324-4493**
Atlanta	**866-889-8202**	**Gainesville**	**770-532-9078**
Augusta	**706-721-2690**	**Savannah**	**912-233-6916**

***Required Field**

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