Anthem BlueCross BlueShield

Member advocate fax referral

Date:	Time:
To (Member Advocate):	
Advocate fax: **262-523-4980**	
Provider name:	
Provider location:	
Provider phone:	Provider fax:
Member's name:	
Member's ID number:	

Reason for referral to the member advocate

☐ Member noncompliance
☐ Problematic with doctor/staff
☐ Appointment no-show
☐ Transportation needed
☐ Request member dismissal from provider
☐ Member needs further education from the health plan
☐ Translation or interpreter services needed
☐ Office staff having difficulty finding a specialist

Describe the reason for member referral to advocate:

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_____
Staff signature

_____
Staff name

_____
Title

_____
Date

Important Note: You are not permitted to use or disclose Protected Health Information (PHI) about individuals who you are not currently treating or have enrolled in your practice. This applies to PHI accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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