Member Appointment No-Show Notification

Please fill in all applicable information then fax this form to Provider Services at **831-430-5857**.

Member's Name: _____ Phone: _____

Alliance ID#: _____ DOB: _____ Appt. Date: _____

Type of Appointment:

❑ Well Child / Physician Exam / Annual Follow-Up ❑ Routine Office Visit ❑ Illness

❑ Immunizations ❑ New Patient ❑ Consult ❑ Post-Partum ❑ Prescription

❑ Blood Pressure Check ❑ Follow-Up on Pregnancy ❑ Other: _____

Was member reminded of appointment by:

❑ Mail ❑ No Mail OR ❑ Phone ❑ No Phone

What have you done to follow up with the patient?

_____

_____

Provider Name: _____ Fax: _____

Provider Staff Contact Name: _____ Date: _____

Alliance Follow-Up

Member Service Representative (MSR) reports: _____

Attempted contact by phone? ❑ No ❑ Yes

If Yes: ❑ Message/Voicemail ❑ Wrong Number ❑ No Answer

If no contact by phone, was letter sent? ❑ No ❑ Yes If Yes, date sent: _____

Comments:

_____

_____

MSR Name: _____ Date Rec'd: _____ Completed

Please fax this completed form to Provider Services at 831-430-5857.