

# Peach State Health Plan Missed Appointment Form

Use this form to refer a member to Peach State Health Plan for outreach.

Date: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member Contact Number: \_\_\_\_\_

Member Address: \_\_\_\_\_

Caregiver Name: \_\_\_\_\_

Provider: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Contact Number: \_\_\_\_\_ Provider Fax Number: \_\_\_\_\_

Please check the reason for the referral:

Missed Appointment(s)

Type of missed appointment(s) \_\_\_\_\_

Date(s) of missed appointment(s) \_\_\_\_\_

Medication non-compliance

Type of medication \_\_\_\_\_

Condition treated by medication \_\_\_\_\_

Other (please explain) \_\_\_\_\_

Please give any additional details

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Please submit this form to Peach State Health Plan's EPSDT Department:

Fax: 1-877-250-5497

Email: PSHP\_EPSDT@CENTENE.COM