

**Member Information Fax Back Form  
Women's Health – Chlamydia Screening**



Member had Chlamydia screening

Date of service (mm/dd/yyyy) \_\_\_\_\_ Result \_\_\_\_\_

**General Information**

This is not my member. PMP is \_\_\_\_\_

I would like this member contacted about care management

Provider Name \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_