Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Member Outreach Form

If you have any questions or concerns, please reach out to **hho-epsdt@highmark.com.**

The information in this box is required. Please complete all lines.

Member name:	
Date of birth:	Member age:
Member ID:	Member phone number:
Parent or guardian name:	
Relationship:	
Date of last EPSDT screening (members age 20 and younger):	
PCP name:	Provider ID:
PCP contact person:	PCP phone number:
Date sent to Highmark Health Options:	

Member outreach is being requested for the following (check all that apply):

☐ Overdue for EPSDT screening. Last screening date:

☐ Delayed immunizations (please specify):

☐ Elevated blood lead level: µg/dL. Date drawn:

Member notified? ☐ Yes ☐ No

(If yes, please attach letter mailed to member or indicate the date of the phone call:)

☐ Psychosocial barriers identified. (Please provide the details in the comment section below.)

☐ Member education regarding referral use.

☐ Referred for services. Services needed (specify):

Referred to: Phone:

Comments:

Would referring office like a callback? ☐ Yes ☐ No

Fax or email the completed form to Care Coordination at **1-855-476-4206** or **HHO-CareCoordinationIntake@highmark.com**.

HIGHMARK HEALTH OPTIONS