Early Periodic Screening Diagnosis and Treatment (EPSDT)

Member Outreach Form

The information in this section is required. ***Complete all fields.***

Member Name: _____ Member ID Number: _____ DOB: ___ /___ /___

Member Age: _____ Member Phone Number: _____

Parent/Guardian Name: _____ Relationship: _____

Date of Last EPSDT Screen (member <21 years old): _____

PCP Name: _____ Provider ID Number: _____

PCP Contact Person: _____ PCP Phone: _____

Date Sent: ___ /___ /___

Outreach is being requested for the following: *(Check all that apply)*

_____ Overdue for EPSDT Screen (please specify last screening date): _____

_____ Delayed immunizations (please specify): _____

_____ Elevated Blood Lead Level: _____µg/dL DOB: ___ /___ /___ Member notified: ___ **No** ___ **Yes**
(If yes, please attach letter mailed to member or indicate the date of the phone call ___ /___ /___)

_____ Psychosocial barriers identified (please specify): _____

_____ Member Education Regarding Referral Use

_____ Referred for Services: Services Needed (please specify): _____

Referred to: _____ Phone: _____

Comments:

HIGHMARK HEALTH OPTIONS

Return via fax to:
Care Management
1-833-559-2849

Would referring office like a call back? ___ No ___ Yes