HIGHMARK WHOLECARE

Member Outreach Form

The information in this box is required. Please complete all lines.		
Member Name:	Age:	Date of Birth:
Date of Last Screening (for Members less than 21 Years Old)	Health ID Number:	
Parent/Guardian Name:	Relationship:	Phone Number:
PCP Name	Provider ID Number	
PCP Contact Person	PCP Contact Phone Number	Date Sent

Member is being referred for the following:

(Highmark Wholecare will call the member to educate, to assist with scheduling appointments and transportation as needed.)

❑ **Referring Office Call Back**
Name: _____
Phone Number: _____

❑ **Overdue for screening**
Last Screening Date: _____

❑ **Behind on immunizations** _____
_____
_____

❑ **Chronic no show for appointments or follow up care**
Date of missed appointments: _____
Reason for appointments: _____
_____

❑ **Member Education** _____
_____

❑ **Test Results (e.g. Elevated Lead Levels)**
Date of last Draw: _____
Result of last Draw: _____
Date script was given for Blood Lead Level: _____
_____

❑ **Overdue for screening**
Last Screening Date: _____

❑ **Referral Services**
Referred for: _____
Physician: _____
Practice: _____
Phone Number: _____
Specialty: _____

❑ **Additional Information** _____
_____

Fax to: Case Management Department (888) 225-2360 | If you have questions concerning the use of this form, call the Case Management Department at 1-800-392-1147.