

# 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.

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