

Date: \_\_\_\_\_

**MEMBER INFORMATION**

Member name:		Date of birth:
Member ID number:		Phone number:
Preferred language:	Preferred contact method (optional; select all that apply): <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Mail	
Is the member aware of this referral (optional): <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/guardian name (if applicable):

**PROVIDER INFORMATION**

Provider name:	Provider ID number:
Role in the member's care team: <input type="checkbox"/> Primary care provider (PCP) <input type="checkbox"/> Specialist	Office contact name:
Phone number:	Email/fax:
Best time to call back:	Follow-up preference: <input type="checkbox"/> Fax <input type="checkbox"/> Call <input type="checkbox"/> Email

**Please check the identified need or intervention:**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Assistance locating a specialty provider, e.g., physical health, behavioral health, trauma specific</li> <li><input type="checkbox"/> Assistance with durable medical equipment (DME), e.g., wheelchair</li> <li><input type="checkbox"/> Assistance with translation services and preferred language materials</li> <li><input type="checkbox"/> Bright Start® maternity program referral<br/>Estimated date of delivery: _____</li> <li><input type="checkbox"/> Care Coordination referral</li> <li><input type="checkbox"/> Caregiver resources</li> <li><input type="checkbox"/> Coaching and education on health conditions</li> <li><input type="checkbox"/> Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)</li> <li><input type="checkbox"/> Education on alternative and proper use of urgent care and emergency services</li> <li><input type="checkbox"/> Education on plan benefits and resources</li> <li><input type="checkbox"/> Frequent emergency room utilization</li> <li><input type="checkbox"/> Identified care gaps</li> <li><input type="checkbox"/> In need of dental provider</li> <li><input type="checkbox"/> Multiple missed appointments or follow-up care</li> <li><input type="checkbox"/> Nonadherence with treatment plan</li> <li><input type="checkbox"/> Pharmacy consult on controlled substances</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Assistance with scheduling and transportation, e.g., recent discharge or appointments</li> <li><input type="checkbox"/> Recent exposure to trauma or stressful life events (e.g., natural disaster, bullying, violence, loss of job, or death in the support system)</li> <li><input type="checkbox"/> Risk of prescribed medication nonadherence</li> <li><input type="checkbox"/> Screening for mental health or substance use services</li> <li><input type="checkbox"/> Tobacco cessation</li> <li><input type="checkbox"/> Weight management</li> <li>Assistance identifying resources for the following social determinants of health (SDOH):               <ul style="list-style-type: none"> <li><input type="checkbox"/> Education and employment</li> <li><input type="checkbox"/> Food and nutrition</li> <li><input type="checkbox"/> Financial (budget/utilities)</li> <li><input type="checkbox"/> Housing resources</li> <li><input type="checkbox"/> Transportation</li> <li><input type="checkbox"/> Vital records</li> </ul> </li> <li><input type="checkbox"/> Treatment plan coaching and education support</li> <li><input type="checkbox"/> Additional comments:</li> </ul> <div style="border: 1px solid black; height: 80px; width: 100%; margin-top: 5px;"></div> |
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**Please fax this form to the Rapid Response and Outreach Team at 1-833-564-3290.**

For guidance on completing this form, or to inquire about a submission, please call **1-833-464-7768**.

**Internal use only:**

Note: Rapid Response and Outreach Team to follow up with provider office staff after outreach to member to report interventions.