

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"> <input type="checkbox"/> Assistance locating a specialty provider, e.g., physical health, behavioral health, trauma specific <input type="checkbox"/> Assistance with durable medical equipment (DME), e.g., wheelchair <input type="checkbox"/> Assistance with translation services and preferred language materials <input type="checkbox"/> Bright Start® maternity program referral
Estimated date of delivery: _____ <input type="checkbox"/> Care Management referral <input type="checkbox"/> Caregiver resources <input type="checkbox"/> Coaching and education on health conditions <input type="checkbox"/> Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide) <input type="checkbox"/> Education on alternative and proper use of urgent care and emergency services <input type="checkbox"/> Education on plan benefits and resources <input type="checkbox"/> Frequent emergency room utilization <input type="checkbox"/> Identified care gaps <input type="checkbox"/> In need of dental provider <input type="checkbox"/> Multiple missed appointments or follow-up care <input type="checkbox"/> Nonadherence with treatment plan <input type="checkbox"/> Pharmacy consult on controlled substances | <ul style="list-style-type: none"> <input type="checkbox"/> Assistance with scheduling and transportation (e.g., recent discharge or appointments) <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) <input type="checkbox"/> Risk of prescribed medication nonadherence <input type="checkbox"/> Screening for mental health or substance use services <input type="checkbox"/> Tobacco cessation <input type="checkbox"/> Weight management Assistance identifying resources for the following social determinants of health (SDOH) and/or health-related social needs: <ul style="list-style-type: none"> <input type="checkbox"/> Education and employment <input type="checkbox"/> Food and nutrition <input type="checkbox"/> Financial (budget/utilities) <input type="checkbox"/> Housing resources <input type="checkbox"/> Transportation <input type="checkbox"/> Treatment plan coaching and education support <input type="checkbox"/> Additional comments: |
|---|---|

Please fax this form to the Rapid Response and Outreach Team at 1-866-426-7309.

For guidance on completing this form, or to inquire about a submission, please call **1-888-643-0005**.

Internal use only:

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