

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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