HIGHMARK HEALTH OPTIONS

EPSDT
Member Outreach Form

Complete and **fax** all requested information below to Highmark Health Options Care Coordination at **1-855-501-3903**. **Questions?** Contact the EPSDT Coordinator at HHO-EPSDT@highmark.com.

Member Information		
Member Name		**Member ID**
Phone	**Date of Birth**	**Age**
Parent/Guardian Name		**Relationship**
Date of last EPSDT Screen (for members 21 years old and younger)		
PCP Name		**Provider ID**
PCP Contact Person		**PCP Phone**
Date information sent to Care Coordination		

Member Outreach Checklist
☐ **Is member overdue for EPSDT Screen?**
☐ **Does member have any delayed immunizations?** (please specify)
☐ **Does member have an elevated blood lead level?** **µg/dL** _____ **Date drawn** _____ **Member notified?** ☐ **Yes** ☐ **No**
If member notified, attach a copy of letter or provide date of phone call: _____
☐ **Identify member's psychosocial barriers, if applicable.**
☐ **Has member education been conducted for referral use?**
☐ **If member referred for services, provide services needed** (please specify)

Referred to	**Phone**

Additional comments