HIGHMARK® Delaware
HEALTH OPTIONS

Early Periodic Screening Diagnosis and Treatment (EPSDT)
MEMBER OUTREACH FORM

The information in this box is require. Please complete all lines

Member Name:_____ID#:_____DOB:____/____/____

Member Age :_____Member Phone Number:_____

Parent/Guardian Name:_____Relationship:_____

Date of Last EPSDT Screen (members <21 years old):_____

PCP Name:_____Provider ID#_____

PCP Contact Person:_____PCP Phone #:_____

Date Sent to Health Options: _____/_____/_____

Member Outreach is being requested for the following:
(Check all that apply)

___Overdue for EPSDT Screen: last screening date: _____

___Delayed immunizations (please specify):_____

___Elevated Blood Lead Level:_____µg/dL Date drawn_____/_____/_____ Member notified ____No___Yes (If yes, please attach letter mailed to member or indicate the date of the phone call _____/_____/_____)

___Psychosocial barriers identified (Please provide the details in the comment section below)

___Member Education Regarding Referral Use

___Referred for Services: Services Needed (specify)_____

Referred to :_____Phone#:_____

Comments:_____

_____

_____

_____

Please fax to:
Care Coordination Department
Fax: 1-855-501-3903

Would referring office like call back: ____ Yes ____ No

If you have a question concerning the use of this form, call the EPSDT Coordinator, Kim York at 302-317-5944