Fax or email the completed form to Care Coordination
855-476-4206 | HHO-CareCoordinationIntake@highmark.com

Member Outreach Form

Date: _____

Member Information

Member name	Date of birth
Member ID	Phone
Preferred language	Preferred contact method (optional; select all that apply): ☐ Phone ☐ Mail ☐ No preference
Is the member aware of this referral (optional): ☐ Yes ☐ No	Parent/guardian (if applicable)

Provider Information

Provider name	Provider ID
Role in the member's care team: ☐ Primary care provider (PCP) ☐ Specialist ☐ Other	Office contact name
Phone	Email/Fax
Best time to call back	Follow-up preference: ☐ Phone ☐ Email ☐ Fax

Please check the identified need:

Help identifying resources for the following Health-Related Social Needs (HRSN):

- ☐ Education and employment
- ☐ Food and nutrition
- ☐ Finances (budget/utilities)
- ☐ Housing resources
- ☐ Transportation
- ☐ Vital records
- ☐ Help scheduling appointments or transportation

Help finding a provider:

- ☐ Primary care physician (PCP)
- ☐ Specialist (e.g., endocrinology, behavioral health, trauma specific)
- ☐ Vision
- ☐ Dental

- ☐ Help with durable medical equipment (DME)
- ☐ Translation services and preferred language materials
- ☐ MOM Options Maternity Program referral
  Estimated date of delivery: _____
- ☐ Case management referral
- ☐ Care gaps or EPSDT
- ☐ Caregiver resources
- ☐ Self-directed attendant care (SDAC)
- ☐ Respite care

Coaching and education on:

- ☐ Health conditions
- ☐ Plan benefits and resources
- ☐ Site of care (e.g., proper use of urgent care and emergency services)
- ☐ Crisis follow-up resources (recent suicide attempt or bereavement after death by suicide)
- ☐ Multiple missed appointments or follow-up care
- ☐ Treatment plan nonadherence
- ☐ Medication nonadherence
- ☐ Pharmacy consult on controlled substances
- ☐ Screening for mental health or substance use
- ☐ Tobacco cessation
- ☐ Weight management

Other/additional comments: