

# Early Periodic Screening Diagnosis and Treatment (EPSDT)

## Member Outreach Form

The information in this section is required. **Complete all fields.**

Member Name: \_\_\_\_\_ Member ID Number: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_

Member Age: \_\_\_\_\_ Member Phone Number: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Last EPSDT Screen (member <21 years old): \_\_\_\_\_

PCP Name: \_\_\_\_\_ Provider ID Number: \_\_\_\_\_

PCP Contact Person: \_\_\_\_\_ PCP Phone: \_\_\_\_\_

Date Sent: \_\_\_ / \_\_\_ / \_\_\_

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

\_\_\_\_\_ Overdue for EPSDT Screen (please specify last screening date): \_\_\_\_\_

\_\_\_\_\_ Delayed immunizations (please specify): \_\_\_\_\_

\_\_\_\_\_ Elevated Blood Lead Level: \_\_\_\_\_  $\mu\text{g}/\text{dL}$  DOB: \_\_\_ / \_\_\_ / \_\_\_ Member notified: \_\_\_ **No** \_\_\_ **Yes**  
(If yes, please attach letter mailed to member or indicate the date of the phone call \_\_\_ / \_\_\_ / \_\_\_)

\_\_\_\_\_ Psychosocial barriers identified (please specify): \_\_\_\_\_

\_\_\_\_\_ Member Education Regarding Referral Use

\_\_\_\_\_ Referred for Services: Services Needed (please specify): \_\_\_\_\_

Referred to: \_\_\_\_\_ Phone: \_\_\_\_\_

Comments:



Return via fax to:  
**Care Management**  
**1-833-559-2849**

Would referring office like a call back? \_\_\_ **No** \_\_\_ **Yes**