

## LET US KNOW PROGRAM

Date: \_\_\_\_\_

### MEMBER INFORMATION

Member name:		Date of birth:
Member ID number:		Phone number:
Preferred language:	Preferred contact method (optional; select all that apply): <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Mail	
Is the member aware of this referral (optional): <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/guardian name (if applicable):

### PROVIDER INFORMATION

Provider name:	Provider ID number:
Role in the member's care team: <input type="checkbox"/> Primary care provider (PCP) <input type="checkbox"/> Specialist	Office contact name:
Phone number:	Email/fax:
Best time to call back:	Follow-up preference: <input type="checkbox"/> Fax <input type="checkbox"/> Call <input type="checkbox"/> Email

### Please check the identified need or intervention:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Assistance locating a specialty provider (e.g., physical health, behavioral health, trauma specific)</li> <li><input type="checkbox"/> Assistance with durable medical equipment (DME) (e.g., wheelchair)</li> <li><input type="checkbox"/> Assistance with translation services and preferred language materials</li> <li><input type="checkbox"/> Bright Start<sup>®</sup> maternity program referral<br/>Estimated date of delivery: _____</li> <li><input type="checkbox"/> Care Management referral</li> <li><input type="checkbox"/> Caregiver resources</li> <li><input type="checkbox"/> Coaching and education on health conditions</li> <li><input type="checkbox"/> Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)</li> <li><input type="checkbox"/> Education on alternative and proper use of urgent care and emergency services</li> <li><input type="checkbox"/> Education on plan benefits and resources</li> <li><input type="checkbox"/> Frequent emergency room utilization</li> <li><input type="checkbox"/> Identified care gaps</li> <li><input type="checkbox"/> In need of dental provider</li> <li><input type="checkbox"/> Multiple missed appointments or follow-up care</li> <li><input type="checkbox"/> Nonadherence with treatment plan</li> <li><input type="checkbox"/> Pharmacy consult on controlled substances</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Assistance with scheduling and transportation (e.g., recent discharge or appointments)</li> <li><input type="checkbox"/> Recent exposure to trauma or stressful life events (e.g., natural disaster, bullying, violence, loss of job, or death in the support system)</li> <li><input type="checkbox"/> Risk of prescribed medication nonadherence</li> <li><input type="checkbox"/> Screening for mental health or substance use services</li> <li><input type="checkbox"/> Tobacco cessation</li> <li><input type="checkbox"/> Weight management</li> <li><input type="checkbox"/> Assistance identifying resources for the following social determinants of health (SDOH) and/or health-related social needs (HRSN): <ul style="list-style-type: none"> <li><input type="checkbox"/> Education and employment</li> <li><input type="checkbox"/> Food and nutrition</li> <li><input type="checkbox"/> Financial (budget/utilities)</li> <li><input type="checkbox"/> Housing resources</li> <li><input type="checkbox"/> Transportation</li> </ul> </li> <li><input type="checkbox"/> Treatment plan coaching and education support</li> <li><input type="checkbox"/> Additional comments:</li> </ul> |
|--|---|

**Please fax this form to the Rapid Response and Outreach Team at 1-866-477-7229.**

This form may also be submitted via [NaviNet > Select Your Health Plan > Workflows for this Plan > Forms and Dashboards > Member Intervention Form.](#)

For guidance on completing this form, or to inquire about a submission, please call **1-833-472-7708.**

#### Internal use only:

Note: Rapid Response and Outreach Team to follow up with provider office staff after outreach to member to report interventions.