Date:__________________

Maryland HealthChoice Outreach Services Referral Form

Member Name:_______________________________ DOB:__________ Sex:____ MFC ID#: ___________________

Address:____Phone#:______________________

Emergency Contact:____Relationship:__________________

Address:____Phone#:______________________

Referral Source:____Phone#:______________________

Member PCP:____Phone#:______________________

REASON FOR OUTREACH REFERRAL

_______Assist/Educate w/transportation to medical appointment

_______Assist/Educate w/location of PCP

_______Educate about MCO processes

_______Need contact from Special Needs Coord. (please specify reason below)

_______Provide information about community-based services for:________________________________

_______Assist provider w/scheduling appointment

_______Follow-up on repeated missed appointments
List Dates:______________________________

_______Follow-up on repeated ER usage/educate member to use PCP for care

Other:____

RESULTS OF MEDSTAR FAMILY CHOICE OUTREACH

(check all that apply)

_______Contact made with member to assist with transportation. The following information was provided to the member:____

_______Contact made with member to assist/educate with location of PCP

_______Home visit completed to follow-up with non-compliant member. Results:______________________

_______Referral to the Local Health Dept ACCU for non-compliance; Date sent:______________________

_______Medical Appointment scheduled for Member: Date:__________Provider:_______________________

_______Referral to community-based program; Contact person/phone number:_______________________

____

_______Other:____

Outreach Representative:_______________________________Phone:_____________________________

Please fax form to 410-933-2232 or 1-888-991-2232