LET US KNOW PROGRAM

AmeriHealth Caritas North Carolina

Member Intervention Request Form

Date: _____

MEMBER INFORMATION

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

PROVIDER INFORMATION

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

Please check the identified need or intervention:

☐ Assistance locating a specialty provider, (e.g., physical health, behavioral health, trauma specific)

☐ Assistance with durable medical equipment (DME), (e.g., wheelchair)

☐ Assistance with translation services and preferred language materials

☐ Bright Start® maternity program referral
Estimated date of delivery: _____

☐ Car seat request (following prenatal visit during first trimester)
Date of visit: _____

- ☐ Single birth
- ☐ Multiple birth
  If multiple, please provide detail below:

☐ Care Management referral

☐ Caregiver resources

☐ Coaching and education on health conditions

☐ Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)

☐ Education on alternative and proper use of urgent care and emergency services

☐ Education on plan benefits and resources

☐ Frequent emergency room utilization

☐ Identified care gaps

☐ In need of dental provider

☐ Multiple missed appointments or follow-up care

☐ Nonadherence with treatment plan

☐ Pharmacy consult on controlled substances

☐ Assistance with scheduling and transportation, (e.g., recent discharge or appointments)

☐ Recent exposure to trauma or stressful life events (e.g., natural disaster, bullying, violence, loss of job, or death in the support system)

☐ Risk of prescribed medication nonadherence

☐ Screening for mental health or substance use services

☐ Tobacco cessation

☐ Value-added benefits support
Specific request, if any:

_____

☐ Weight management

Assistance identifying resources for the following opportunities for health:

- ☐ Education and employment
- ☐ Food and nutrition
- ☐ Financial (budget/utilities)
- ☐ Housing resources
- ☐ Transportation
- ☐ Vital records

☐ Treatment plan coaching and education support

Additional comments:

Please fax this form to the Rapid Response and Outreach Team at **1-833-816-2262.**
For guidance on completing this form, or to inquire about a submission, please call **1-833-808-2262**.

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