LET US KNOW PROGRAM

AmeriHealth Caritas Next

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Member Intervention Request Form

Date: _____

MEMBER INFORMATION

Member name:	Date of birth:
Member ID number:	Phone number:
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: _____
- ☐ 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
- ☐ Weight management
- ☐ Assistance identifying resources for the following social determinants of health (SDOH) and/or health-related social needs (HRSN):
  - ☐ Education and employment
  - ☐ Food and nutrition
  - ☐ Financial (budget/utilities)
  - ☐ Housing resources
  - ☐ Transportation
- ☐ Treatment plan coaching and education support
- ☐ Additional comments:

Please fax this form to the Rapid Response and Outreach Team at 1-833-770-8329.
For guidance on completing this form, or to inquire about a submission, please call **1-833-435-7708**.

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