LET US KNOW PROGRAM

Rapid Response and Outreach Team Member Intervention Request Form for Provider Referrals

Date: ____________________

Member information	
Member name:	Date of birth:
Member ID number:	Phone number:
Parent or guardian name (if applicable):	

Primary care provider (PCP) information		
PCP name:		PCP ID number:
Phone number:	Fax number:	PCP county:
Office contact name:		Follow-up preference? ☐ Call ☐ Fax

Submitting provider information (if other than PCP)		
Provider name:		Provider ID number:
Phone number:	Fax number:	Provider county:
Office contact name:		Follow-up preference? ☐ Call ☐ Fax

Please check the appropriate reasons for referral (mark all that apply)

- ☐ Non-compliance with prescribed medications
- ☐ Inappropriate use of emergency room
- ☐ Not showing up for appointments or follow-up care
- ☐ Limited or no knowledge of plan benefits
- ☐ Frequent inpatient hospitalizations
- ☐ Persistent or chronic mental or physical illness
- ☐ Inappropriate use of outpatient services
- ☐ Non-compliance with treatment plan
- ☐ Inappropriate behavior
- ☐ Drug-seeking behavior
- ☐ Needs behavioral health assistance or services
- ☐ Multiple missed appointments
- ☐ Needs assistance locating specialty provider
- ☐ Problems or issues with care gaps
- ☐ Other: ____________________

Please send this form to the Rapid Response and Outreach Team by fax at 1-844-399-0477 or by email at DLACIARapidResponseIowa@amerihealthcaritasia.com.

Follow-up performed: ____________________

Comments: ____________________

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