



**DELAWARE FIRST HEALTH MEMBER OUTREACH FORM**

Member Name: \_\_\_\_\_ ID#: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Member Phone Number: \_\_\_\_\_

PCP Name: \_\_\_\_\_ Provider ID# \_\_\_\_\_

PCP Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date sent to Delaware First Health: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Member Outreach Requested: (Check all that apply)**

\_\_\_ Recurring No Show for Appointments (List dates missed) \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_ Frequent Emergency Room Visits

\_\_\_ Psychosocial Barriers Identified (Please provide the details in the comment section below)

\_\_\_ Member Education Regarding Referral Use

\_\_\_ Referred for Services: Services Needed (specify) \_\_\_\_\_

Referred to: \_\_\_\_\_ Phone#: \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please email this form to [DFH\\_MemberAdvocates@Centene.com](mailto:DFH_MemberAdvocates@Centene.com).**

**Call Member Services at 1-877-236-1341 and ask to speak with a Member Advocate.**