delaware first health

Early Periodic Screening Diagnosis and Treatment (EPSDT)
MEMBER OUTREACH FORM

The information in this box is require. Please complete all lines

Member Name: _____ID#:_____DOB:____/____/____

Member Age: _____ Member Phone Number: _____

Parent/Guardian Name: _____Relationship: _____

Date of Last EPSDT Screen (members <21 years old): _____ Last outreach attempt: _____

PCP Name: _____Provider ID#_____

PCP Contact Person: _ _____PCP Phone #: _____

Date Sent to Delaware First Health Plan: _____/_____/_____

Member Outreach is being requested for the following:
(Check all that apply)

___Overdue for EPSDT Screen: last screening date: _____

___Delayed immunizations (please specify): _____

___Elevated Blood Lead Level: _____µg/dL Date drawn_____/_____/_____ Member notified ____No ___Yes

(If yes, please attach letter mailed to member or indicate the date of the phone call _____/_____/_____)

___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#: _____

___Date discharged from the PCP office: _____

Comments: _____

_____

_____

_____

Please email to: EPSDT@DelawareFirstHealth.com **Would referring office like call back: ____ Yes ____ No**

If you have a question concerning the use of this form, call the EPSDT Coordinator, Nicole Alexander at 302-861-4137