# 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):

- ☐ 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 1-833-770-8329.**
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.