

Member Outreach Form



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

Member Name	Age	Date of Birth
Date of Last Screening (for Members less than 21 Years Old)	Gateway Health ID Number	
Parent/Guardian Name	Relationship	Phone Number
PCP Name	Provider ID Number	
PCP Contact Person	PCD Contact Phone Number	Date Sent to GHP

Member is being referred for the following:

(Gateway Health will call the member to educate, to assist with scheduling appointments and transportation as needed.)

Over due for screening

Last Screening Date: _____

Behind on immunizations

Chronic no show for appointments or follow up care

Dates of missed appointments: _____

Reason for appointments: _____

Member Education

Additional Information:

Test Results (e.g. Elevated Lead Levels)

Date of last Draw: _____

Result of last Draw: _____

Date script was given for Blood Lead Level: _____

Notified by mail (attach letter), Notified by phone date: _____

Referral Services

Referred for: _____

Physician: _____

Practice: _____

Phone Number: _____

Specialty: _____

**Fax to: Case Management Department
(888) 225-2360**

**If you have questions concerning the use of this form, call
the Case Management Department at 1-800-392-1147.**

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