Early Periodic Screening Diagnosis and Treatment (EPSDT) Member Outreach Form

Upon completion of this form, please email to: EPSDT@delawarefirsthealth.com.
You may contact EPSDT coordinator, Nicole Alexander with any questions or concerns at (302) 861-4137

Date of Request: _____

MEMBER INFORMATION

Member Name:	DOB:	ID#
Phone Number: ☐ Cell ☐ Landline	Preferred Language:	
Preferred Contact Method: ☐ Call ☐ Text ☐ Email	Email:	
Parent/Guardian Name (if applicable):	Relationship:	
Date of Last EPSDT Screen (Members under 21 yrs of age):	Last Outreach Attempt:	
Is the Member Aware of This Referral? ☐ Yes ☐ No		

PROVIDER INFORMATION

Provider Name:	Provider ID#:
Role in Member's Care Team: ☐ Primary Care Physician (PCP) ☐ Specialist ☐ Other:	
Phone Number:	Email or Fax Number:
Preferred Contact:	Best Time to Call:
Name of Person Completing Form:	Professional Title:

Please indicate identified need(s) for outreach:

☐ Overdue for EPSDT screening

☐ Delayed Immunization(s)(Please Specify):_____

☐ Elevated Blood Level:_____µg/dL Date Drawn: _____ Member Notified: ☐ Yes ☐ No

☐ Psychosocial Barriers Identified:_____

_____

_____

☐ Member Education or Coaching on Plan benefits and Resources (specify):_____

_____

☐ Frequent Emergency Room Utilization

☐ In Need of Specialist

☐ Multiple Missed Appointments or Follow-up Care

☐ Assistance Scheduling Transportation

☐ Other: _____

_____

☐ Assistance with Translation Resources

☐ In Need of Dental Provider

☐ Maternity Program Referral

Assistance Locating Resources for any of the following:

☐ Housing Resources ☐ Food and Nutrition

☐ Education and Employment ☐ Financial Stability

Additional Comments:_____

_____

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