

Outreach Request Form

Please fax completed form to 1-877-299-4225.

Date: _____

Provider Information

Practice Name: _____ Contact Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

Patient Information

Patient Name: _____ Medicaid ID Number: _____

Patient Address: _____
(validate before visit)

Parent/Guardian Name: _____ Phone: _____

Reason for Outreach Request

- Noncompliant
- Health Education Classes (list classes): _____
- New Member Benefits Orientation _____
- No-Show for appointment (list dates): _____
- Community Resources (list need): _____

CRC Outreach Notes (To be completed by Outreach Specialist.)

Outreach Specialist: _____ Phone Number: _____

Date of Home Visit: _____ Number of Family Members: _____

Preferred Language: _____

Notes: _____

Date Faxed to Provider: _____