



OUTREACH SERVICES REFERRAL FORM

FOR PROVIDER USE ONLY

6704 Curtis Ct.
Glen Burnie, MD 21060
FAX: 410-424-4884

Instructions: Complete this form and submit by fax.
You will receive confirmation once processed.

***required information**

Priority Partners PAC

Member Information:	
* Date:	*Date of Birth
*Member Name:	
*Member ID #	*Referring Source:
* Member Phone:	*Referring Telephone:
Emergency Contact:	Emergency Contact Phone:
*Member Address: City: State: Zip code:	*PCP Provider:
	*PCP Email:
	*PCP Phone:

Reason(s) for Outreach Referral (select any of the following options that apply):

- Assist/Educate with transportation to medical appointment
- Assist/Educate with location of PCP
- Educate about MCO process/system of care
- Need contact from Special Needs Coordinator (please specify reason below):
- Notification of Pregnancy
- Assist with appointment scheduling of PCP
- Follow-up on repeated missed appointments (list dates):
- Follow up on repeated emergency room usage, educated member to utilize PCP for care
- Provide information about community resources for:
- Other: _____

List Contact Attempts: #of letters sent _____ # of telephone attempts: _____

OUTREACH SERVICES FOLLOW-UP COMPLETED

- Contact made with member to assist with transportation to medical appointments.
- Contact made with member to assist/educate with location of PCP. Date: _____
- Referral forwarded to Local Health Depart. ACCU for non-compliance. Date: _____
- Medical appointment scheduled. Date: _____
- Other:

Outreach Representative: _____ Telephone: _____