LET US KNOW PROGRAM

Keystone First

Date: _____

Member Intervention Request Form

MEMBER INFORMATION

Member name	Date of birth
Member ID number	Phone number
Parent/guardian name (if applicable)	

PROVIDER INFORMATION

Provider name	PCP ID number
Phone number	Fax number
Office contact name	Best time to call back
How would you like to be notified of the referral final outcome?	
Phone number (if different from above):	Fax number:
Email:	

Please check the appropriate intervention(s):

- ☐ Noncompliance with prescribed medication(s)
- ☐ Education on proper use of the emergency room
- ☐ Not showing up for appointments or follow-up care
- ☐ Limited or no knowledge of plan benefits
- ☐ Education on the importance of following a treatment plan
- ☐ In need of dental treatment
- ☐ In need of behavioral health/drug or alcohol assistance
- ☐ Requesting referral to Care Management program
- ☐ Pregnant member requesting engagement in Bright Start® maternity program
- ☐ Other: _____

Assistance needed with the following social determinants of health domains:

- ☐ Food insecurity resources
- ☐ Housing resources
- ☐ Transportation resources
- ☐ Other (specify): _____

Additional information/comments:

Please fax this form to the Rapid Response and Outreach Team at 1-800-647-5627.

Follow-up performed: _____

Comments: _____

Coverage by Vista Health Plan, an independent licensee of the Blue Cross and Blue Shield Association.