LET US KNOW PROGRAM

Keystone First

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

Member Intervention Request Form

Date: _____

MEMBER INFORMATION

Member name:	Date of birth:
Member ID number:	Phone number:
Preferred language:	Preferred contact method (optional; select all that apply): ☐ Phone ☐ Text ☐ Mail
Is the member aware of this referral (optional): ☐ Yes ☐ No	Parent/guardian name (if applicable):

PROVIDER INFORMATION

Provider name:	Provider ID number:
Role in the member's care team: ☐ Primary care provider (PCP) ☐Specialist	Office contact name:
Phone number:	Email/fax:
Best time to call back:	Follow-up preference: ☐ Fax ☐ Call ☐ Email

Please check the identified need or intervention:

☐ Assistance locating a specialty provider, e.g., physical health, behavioral health, trauma specific

☐ Assistance with durable medical equipment (DME), e.g., wheelchair

☐ Assistance with translation services and preferred language materials

☐ Bright Start® maternity program referral

Estimated date of delivery: _____

☐ Care Management referral

☐ Caregiver resources

☐ Coaching and education on health conditions

☐ Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)

☐ Education on alternative and proper use of urgent care and emergency services

☐ Education on plan benefits and resources

☐ Frequent emergency room utilization

☐ Identified care gaps

☐ In need of dental provider

☐ Multiple missed appointments or follow-up care

☐ Nonadherence with treatment plan

☐ Pharmacy consult on controlled substances

☐ Assistance with scheduling and transportation, e.g., recent discharge or appointments

☐ Recent exposure to trauma or stressful life events (e.g., natural disaster, bullying, violence, loss of job, or death in the support system)

☐ Risk of prescribed medication nonadherence

☐ Screening for mental health or substance use services

☐ Tobacco cessation

☐ Weight management

Assistance identifying resources for the following social determinants of health (SDOH) and/or health-related social needs:

- ☐ Education and employment
- ☐ Food and nutrition
- ☐ Financial (budget/utilities)
- ☐ Housing resources
- ☐ Transportation

☐ Treatment plan coaching and education support

☐ Additional comments:

Please fax this form to the Rapid Response and Outreach Team at 1-800-647-5627.
For guidance on completing this form, or to inquire about a submission, please call **1-800-573-4100**.

Internal use only:
Note: Rapid Response and Outreach Team to follow up with provider office staff after outreach to member to report interventions.