

CHNCT Quality Improvement Outreach Services

Instructions For Requesting Member Outreach

(External)

Requests for outreach should be typed on the Outreach Request Form. The latest version is dated 08/29/05 and older versions should be discarded. All requests are to be forwarded to the attention of the Outreach Manager. For tracking purposes requests are not to be given directly to the Care Coordinators.

Request Form

Section I: Member Information

Please fill this section out completely. Researching missing or incorrect information will delay the turnaround time. Generally requests are returned within ten (10) business days, unless otherwise noted by the requestor.

If “Date Needed” is left blank, it will be our presumption that Outreach Staff will have a longer period of time to complete the request.

Section II: Reason For Request

For tracking purposes, only 1 option may be selected, and it should be the “main” reason for the request.

Section III: Requestor’s Additional Comments

Use this section if you need to provide additional information regarding the nature of the request, e.g., background information, member history, former PCP, etc. Please do not make stray notes on the request form.

The completed request can be mailed or faxed to the Outreach Manager.

Fax: (203) 265-3830

Be sure to include a contact person’s name and telephone number.

CHNCT Quality Improvement REQUEST FOR MEMBER OUTREACH

Date: _____ Requested by: _____
Dept. / Site: _____ Date needed: _____
Member's Name: _____ DOB: ____ / ____ / ____
Member ID#: _____ PH#: _____
Head of Household/Guardian: _____
Address: _____
City: _____ State: _____ Zip: _____
Language Spoken: _____
Primary Care **Dentist** Name: _____
PCD Site: _____ PCD Phone: _____
Primary Care **Provider** Name: _____
PCP Site: _____ PCP Phone: _____

REASON for request (PLEASE ONLY CHECK ONE):

- | | | | |
|------------------------------------|---|---|--|
| <input type="checkbox"/> Dental | <input type="checkbox"/> High Risk Prenatal | <input type="checkbox"/> Newborn Welcome Call | <input type="checkbox"/> Referral Needed |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Member Education | <input type="checkbox"/> No PCP Visits | <input type="checkbox"/> Other (*) |
| <input type="checkbox"/> EPSDT | <input type="checkbox"/> Missed Appointment | <input type="checkbox"/> Prenatal | |
| <input type="checkbox"/> ER Usage | <input type="checkbox"/> Newborn EPSDT | <input type="checkbox"/> Post Partum | |

(*) Please Explain Below under Requestor's Additional Comments

Requestor's Additional Comments:

Outreach Admin: _____ Date: _____
Outreach Care Coordinator: _____ Date: _____

FAX TO THE ATTENTION OF: JANE PIPER, RN, OUTREACH MANAGER
203-265-3830 / or Call 203-949-4000

Requested by: _____	Date: _____
Member's Name: _____	ID #: _____

PHONE ATTEMPTS:		
Date: _____	Time: _____	Notes: _____

FINAL OUTCOME:			
<input type="checkbox"/> Card/Letter Mailed	Date: ___/___/___	Card/Letter Type _____	
	Date: ___/___/___	Card/Letter Type _____	
<input type="checkbox"/> Appointment Made	Date: ___/___/___	Time: _____	
Site: _____	Provider: _____		
<input type="checkbox"/> Safety Education <input type="checkbox"/> PCP Change Submitted <input type="checkbox"/> PCD Change Submitted <input type="checkbox"/> Other Insurance Submitted			
(Please Only check ONE)			
<input type="checkbox"/> Completed	<input type="checkbox"/> Needs More Follow-up		
<input type="checkbox"/> Unreachable	<input type="checkbox"/> Other: (Specify) _____		

Outreach Care Coordinator Sign off: _____	Date: _____
Outreach Admin. Sign off: _____	Date: _____

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