LET US KNOW PROGRAM

AmeriHealth Caritas District of Columbia

Enrollee Intervention Request Form

Date: _____

ENROLLEE INFORMATION

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

PROVIDER INFORMATION

Provider name:	Provider ID number:
Role in the enrollee'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 1-888-607-6405.
For guidance on completing this form, or to inquire about a submission, please call **1-877-759-6224**.

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

DHCF This program is brought to you by the Government of the District of Columbia Department of Health Care Finance

GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR