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| Date:     /   /  To:  Attention:  Address:  City/State/Zip:  Phone: |

**HealthChoice**

**LOCAL HEALTH SERVICES**

**REQUEST FORM**

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| **Client Information** | |
| Client Name:  Address:  City/State/Zip:  Phone:  County:  DOB:      /   /     SS#:    -    -  Sex: M F Hispanic: Y N  MA#:  Private Ins.:  No Yes  Martial Status: Single Married Unknown  If Interpreter is needed specific language: | Race: African-American/Black  Alaskan Native American Native  Asian Native Hawaiian  Pacific Islander White  More than one race Unknown |
| Caregiver/Emergency Contact:  Relationship:  Phone: |
| FOLLOW-UP FOR: (Check all that apply)  Child under 2 years of age  Child 2 – 21 years of age  Child with special health care needs  Pregnant EDD: \_\_\_\_ / \_\_\_\_ /\_\_\_\_  Adults with disability(mental, physical, or  developmental)  Substance use care needed  Homeless (at-risk) | RELATED TO: (Check all that apply)  Missed appointments:     #missed  Adherence to plan of care  Immunization delay  Preventable hospitalization  Transportation  Other: |
| Diagnosis: | |
| Comments: | |

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| **MCO:** | Date Received:     /   / |
| Document Outreach:  # Letter(s)       # Phone Call(s)  # Face to Face | Unable to Locate |
| Contact Date:     /   / |
| Advised Refused |
| Comments: | |
| Contact Person:  Phone:  Fax: | Provider Name:  Provider Phone: |

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| **Local Health Department (County)** | Date Received:     /   / |
| Document Outreach:  # Letter(s)       # Phone Call(s)  # Face to Face | No Action (returned)  Reason for return: |
| Disposition:  Contact Complete: Date:     /   /  Unable to Locate: Date:    /   /  Referred to:       Date:     /   / |
| Contact Person:  Contact Phone: |
| Comments: | |