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

**HealthChoice**

**LOCAL HEALTH SERVICES**

**REQUEST FORM**

|  |
| --- |
| **Client Information** |
| Client Name:       Address:       City/State/Zip:       Phone:       County:       DOB:      /   /     SS#:    -    -     Sex: [ ] M [ ] F Hispanic: [ ] Y [ ] NMA#:      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:        |