Reach for Escalation Form

PROVIDERS This form is used to make it easier for you to obtain help for your patient(s) by contacting the Member Engagement Services Escalation Unit.

HUSKY HEALTH CONNECTICUT

Call 1.800.440.5071, select #1

Submit the completed form via:
Email: Reachforescalation@chnct.org • Fax: 203.265.3197

Today's Date: _____ Provider NPI: _____

Provider Office Contact Name: _____ Provider Office Phone: _____

1. Member Name (Last, First):	2. HUSKY Member ID (9 characters):
3. Member Date of Birth (MM/DD/YYYY):	4. Member Current Street Address (Street/Town/Zip):
5. Best way to reach the member: ☐ Phone ☐ Email	6. Best phone number to reach the member:
7. Member email (if known):	8. Would you like us to contact the member directly? ☐ Yes ☐ No

9. I would like to receive updates via: ☐ Fax ☐ Email ☐ Phone

10. What can we help you find? *Check all that apply*
- ☐ Help me find a specialist for this patient
- ☐ Help me find a PCP for this patient
- ☐ Help me find an ancillary provider (PT/OT/ST/Audiology, Home Care, Vision, etc.)
- ☐ Help me find a DME provider for this patient
- ☐ Help! Interruption in HUSKY eligibility or other insurance (that is still listed, but no longer active) is preventing care
- ☐ Help this patient with community resources/free or low cost care
- ☐ Other *(please state)* _____

If assistance with locating a provider is needed, please complete #11-14

11. If a specialist or ancillary provider is needed, what provider type(s) is needed? (e.g. cardiology, orthopedics, etc.)

12. By what date? MM/DD/YYYY

13. What is the member's diagnosis?

14. What service(s) / procedure(s) / treatment(s) is needed?

If care is being prevented or interrupted due to the presence of other insurance that is no longer active or an eligibility issue, please complete #15

15. What care is prevented or interrupted?
- ☐ Ongoing appointments
- ☐ Medications *(please state)*_____
- ☐ Ancillary services (PT/OT/HC/etc.)
- ☐ Transportation to medical appointments
- ☐ Other *(please state)*_____

If assistance in locating DME is needed, please complete #16-18

16. What item(s) does the member need?

17. By what date? MM/DD/YYYY

18. What is the member's diagnosis?

If you would like us to help with free or low cost initiatives or community resources, please complete #19

19. What is the member having trouble with?
- ☐ Food
- ☐ Clothing
- ☐ Shelter
- ☐ Parenting
- ☐ Energy Assistance
- ☐ Employment/Vocational Support
- ☐ Support Groups or Advocacy Agencies
- ☐ Other *(please state)*_____
- ☐ I am not sure; please assess