

## Member Information Fax Back Form Children's Health - Lead Screening



Member had a childhood lead screening test

Date of visit \_\_\_\_\_

Type of Test:

Capillary

Venous

neither

### General Information

This is not my member. PMP is \_\_\_\_\_

I would like this member contacted about care management

Provider Name \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_