Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Health Plan: Boston Medical Center HealthNet Plan   Network Health   Fallon Community Health Plan   Neighborhood Health Plan   PCC Plan   HNE

The member below is currently receiving services and has consented to share the following information between his/her PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information.

Member name: ______________________ DOB: __________ Member ID#: __________

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: ________________

Section A: *(completed by BH Provider)*

1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)

________________ ________________

________________ ________________

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

________________ ________________

________________ ________________

________________ ________________

Prescriber: ______________________

3. The patient has the following substance abuse problem(s) (if applicable):

____

____

____

4. Please describe any special concerns:

____

____

____

____

Behavioral Health Clinician: ________________

Behavioral Health Clinician Signature: ________________

Provider Name/Site Name: ________________

Address: ________________

____

____

Phone: ________________

Fax: ________________

Date this form completed:

Section B: *(completed by Primary Care Provider)*

1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)

________________ ________________

________________ ________________

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

________________ ________________

________________ ________________

________________ ________________

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

____

____

4. Please describe any special concerns (i.e., include abnormal lab results):

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____

Primary Care Provider: ________________

Primary Care Provider Signature: ________________

Provider Name/Site Name: ________________

Address: ________________

____

____

Phone: ________________

Fax: ________________

Date this form completed:

To make a referral to Care Management, please call the members' plan at:

Boston Medical Center HealthNet Plan: (866) 444-5155 • Network Health: (888) 257-1986 • Fallon Community Health Plan: (888) 421-8861

Neighborhood Health Plan: (800) 414-2820 • Primary Care Clinician Plan: (617) 790-5633 • Health New England: (617) 790-5633

(Updated 10/15/2010)