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):

_____

_____

_____

_____

_____

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: (800) 495-0086 • Health New England: (800) 786-9999

(Updated 9/20/2012)