TUFTS Health Plan

Behavioral Health (BH)/Primary Care Provider (PCP) Communication Form – Tufts Health RITogether

Today's date: ____/____/____

Member name: ______________________________

Member DOB: _______________________________

Member ID #: _______________________________

This member is currently receiving services and has consented to share the following information between their PCP and BH provider.

A signed copy of the release of information (ROI) must be attached to this form.

Date of expiration of ROI: ____/____/____

Send this form to the following address or fax number:

Tufts Health Plan
Attn: Medical Management Intake Services
75 Fountain Street Floor 1
Providence, RI 02903-0050

Fax: 857.304.6404

To refer a member to Care Management, call 844.301.4093.

Section A: (To be completed by BH provider)	**Section B: (To be completed by PCP)**
☐ The patient is being treated for the following BH health issue(s) and/or diagnosis (list all): __________ __________ __________	☐ The patient is being treated for the following medical issue(s) and/or diagnosis (list all): __________ __________ __________
☐ The patient is taking the following medications (list all prescriptions and OTC medications with dosage and frequency): __________ __________ __________ Prescriber: __________	☐ The patient is taking the following medications (list all prescriptions and OTC medications with dosage and frequency): __________ __________ __________ Prescriber: __________
☐ The patient has the following substance use issue(s), if applicable: __________ __________	☐ The patient has the following substance use issue(s), if applicable: __________ __________

TUFTS Health Plan

____	____
☐ Describe any special concerns: ____ ____ ____	☐ Describe any special concerns (e.g., include abnormal results: ____ ____ ____
BH provider: ____	PCP: ____
BH provider signature: ____	PCP signature: ____
Provider/site name: ________________________ Address: __________________________________ City: ____________ State: ______ ZIP: _________ Phone: ___________________ Fax: ____________ Date this form was completed: _____/______/________	Provider/site name: ________________________ Address: __________________________________ City:____________ State:_______ ZIP:_________ Phone: __________________ Fax: _____________ Date this form was completed: _____/______/________