Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Health Plan: Boston Medical Center HealthNet Plan • CeltiCare Health • Health New England • Fallon Health • Neighborhood Health Plan • Tufts Health Plan • PCC Plan

The member below is currently receiving services and has consented to share the following information between their 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:_____ Date of birth:_____ 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: (*to be completed by BH provider*)	**Section B**: *(to be completed by Primary Care Provider)*
1. The patient is being treated for the following behavioral health problem(s) and/or diagnosis: (list all) _____ _____ _____ _____	1. The patient is being treated for the following medical problem(s) and/or diagnosis: (list all) _____ _____ _____ _____
2. The patient is taking the following medications: (list all prescriptions and OTC medications with dosage and frequency) _____ _____ _____ _____ _____ _____ Prescriber: _____	2. The patient is taking the following medications: (list all prescriptions and OTC medications with dosage and frequency) _____ _____ _____ _____ _____ _____ Prescriber: _____
3. The patient has the following substance use problem(s), if applicable: _____ _____ _____	3. The patient has the following BH (MA/SA) problems, if applicable: _____ _____
4. Please describe any special concerns: _____ _____	4. Please describe any special concerns (i.e., include abnormal lab results): _____ _____
Behavioral Health Clinician:_____ Behavioral Health Clinician signature:_____ Provider Name/Site Name:_____ Address:_____ _____ _____ Phone:_____ Fax:_____ Date this form completed:_____	Primary Care Provider:_____ Primary Care Provider's signature:_____ Provider Name/Site Name:_____ Address:_____ _____ _____ Phone:_____ Fax:_____ Date this form completed:_____

To refer a member to Care Management, please call the member's plan at:
Boston Medical Center HealthNet Plan: (866) 444-5155 • CeltiCare Health: (866) 895-1786 • Fallon Health: (888) 421-8861 • Health New England: (800) 786-9999 • Neighborhood Health Plan: (800) 414-2820 • Tufts Health Plan: (888) 257-1985