Behavioral Health and Primary Care Provider Coordination of Care Form

The coordination of physical and behavioral health care among treating providers is essential for safe and effective care. Please complete applicable sections of this document and include signed consent for releasing information, as appropriate.

	Date:
Patient name:	Date of Birth:
Medicaid/Marketplace/Medicare ID:	

Behavioral Health Provider	Physical Healthcare Provider
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Dear Colleague:

I am treating the member for the following diagnosis(es): _____

_____

The member is engaged in the following intervention(s): ☐Psychotherapy ☐Medication Management
☐ Other (specify) _____

Frequency of intervention(s):

_____

Lab Tests: ☐ CBC ☐ Thyroid Studies ☐ EKG ☐ Lipid Profile ☐ Serum drug level (specify drug)

_____

Medications prescribed (or attach list)

Medication	Dose	Frequency

☐Member Refused Medication

Adherence to Medications: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Adherence to Appointments: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Response to Treatment: ☐ Improving with treatment ☐ Stable with treatment ☐ Not improving ☐ No information

Coordination of care issues or other significant information affecting medical or behavioral health care:

_____

_____

_____

Provider signature: _____ Date: _____

CareSource has Case Managers available to assist with coordination of care. Please return a copy of this form via fax to (937) 396-3964 or email Indiana_BH@caresource.com and a Case Manager will assist with care coordination efforts.

Please check if you DO NOT want the following protected health information released:
☐ Substance Abuse ☐ HIV/AIDS

This authorization will expire on _____. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by _____ will not be affected if I do not sign this form. The information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Patient Signature: _____

Date: _____