Combined Behavioral Health Provider/Primary Care Provider Communication Form

If you are unsure of the patient's assigned PCP, for Medicaid please contact Harmony Customer Service Department at **1-800-608-8158** or Medicare Customer Service Department at **1-855-538-0454** for further assistance.

Please update this form annually or when there has been a significant change in the patient's status.

Health Plan: Harmony/WellCare of IL

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:_____ DOB:_____ Member ID#:_____

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

Section A: (completed by BH Provider & forwarded to PCP)

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: _____

The patient has the following substance abuse issues(s) (current, past medical history or behavioral health history /if applicable)

_____

_____

_____

3. 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 & returned to BH 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)

_____ _____

_____ _____

Prescriber: _____

3. The patient has the following BH (MH/SA) issues(s) (current, past medical history or behavioral health history/if applicable)

_____

_____

_____

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

_____

_____

_____

_____

Primary Care Provider: _____
Primary Care Provider Signature: _____
Provider Name/Site Name: _____
Address:
_____
_____
_____
Phone: _____
Fax:_____
Date this form completed:
_____