

PRIMARY CARE PHYSICIAN (PCP)/ BEHAVIORAL HEALTH (BH) PROVIDER COMMUNICATION FORM

In an effort to increase communication and promote care coordination between providers, we ask that you please review and complete the following information.

Patient Name: _____ DOB: _____

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 PCP	Section B: Completed by BH Provider
<p>1. The patient is being treated for the following medical problem(s) and/or diagnoses (<i>list all</i>):</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>1. The patient is being treated for the following BH problem(s) and/or diagnoses (<i>list all</i>):</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>2. The patient is taking the following medication(s) (<i>list all</i>), including over-the-counter:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Prescriber: _____</p>	<p>2. The patient is taking the following medication(s) (<i>list all</i>), including over-the-counter:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Prescriber: _____</p>
<p>3. Please describe any special concerns (<i>i.e. include abnormal lab results</i>):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>PCP: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Date this form completed: _____</p>	<p>3. Please describe any special concerns (<i>i.e. include abnormal lab results</i>):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>BH Provider: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Date this form completed: _____</p>

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