

BEACON



HEALTH STRATEGIES

Primary Care Professional Behavioral Health Communication Form

Member's Health Plan: NHP (MA) NHPRI FCHP Date: _____

ATTENTION PCP:

The patient listed below is currently receiving behavioral health services and has consented to share the following information with their PCP. In an effort to increase communication and promote care coordination between providers, we ask that you review the behavioral health information in Section A. Please complete the medical information in Section B.

Member Name: _____ DOB: _____

Insurance Plan: _____ Insurance ID#: _____

SECTION A

Please attach a signed copy of the information release form

1) Diagnosis:

AXIS I: _____

AXIS II: _____

AXIS III: _____

2) Current medication (dosage/frequency): _____

3) Current treatment and expected duration (modalities/frequency): _____

Behavioral Health Clinician: _____

Psychopharmacologist, if applicable: _____

Address: _____

Phone: _____ Fax: _____

SECTION B

PCP: Please contact the above Behavioral Health Provider via phone or fax with the following information:

Copy of patient's last physical and date of last appointment: _____

Medical Information (*i.e.* Medication, medical concerns): _____

Signature of Provider completing communication form: _____