



The Best Care. Because We Care.

BH/PMP Coordination of Care Form

Member Name: _____ Date: _____

Clinician Name: _____ Member Medicaid ID: _____

Clinician Address: _____

Clinician Phone: _____ Fax: _____

Dear Colleague:

The above-named member was seen for initial behavioral health evaluation on _____

for _____

(Reason/Diagnosis)

Brief Summary (if indicated):

Current Treatment:

- Psychotherapy
- Medication
- Member Refused Medication

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

Diagnostic Tests:

Please check if you **DO NOT** want the following protected health information released: Behavioral Health Substance Abuse

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. Signature: _____