COMMUNITY FIRST
HEALTH PLANS

Communication Form

Behavioral Health and Medical Providers: Continuity and Coordination of Care

This form was created to help facilitate continuity and coordination of care between the medical and behavioral health providers for the Community First Health Plans Member listed below.

INSTRUCTIONS

Behavioral Health Providers: Please complete SECTION A of this form and fax or mail to the Member's PCP. Please attach a copy of the release form signed by the Member as proof of consent that this information may be shared with the Member's PCP.

Primary Care Providers: The patient listed below is currently receiving behavioral health services and has consented to share the following information. Please review SECTION A of this form. Save a copy for your records. Please then complete SECTION B of this form and return it via fax or mail to the Member's behavioral health provider. Please also attach a copy of dated notes from the Member's last PCP visit.

SECTION A

This section should be completed by the Behavioral Health Provider.

Member Name: Member ID #:

Member DOB (MM/DD/YYYY): BH Provider Name:

Address: Suite #:

City: State: Zip Code:

Phone Number: Fax Number:

1. The patient is being treated for the following behavioral health problems (please list all diagnoses):

2. The patient is taking the following prescribed psychotropic medication(s) (please list all medications and dosages):

3. The patient has the following substance abuse issue(s) (if applicable):

4. Please describe any additional concerns:

5. I have attached a signed copy of the release of this information to this form. ☐ YES ☐ NO

SECTION B

This section should be completed by the Primary Care Provider.

PCP Name:

Address: Suite #:

City: State: Zip Code:

Phone Number: Fax Number:

Date of Patient's Last PCP Visit:

1. The patient is being treated for the following medical problem(s) and/or diagnoses (please list all):

2. The patient is taking the following medications (please list all prescribed and OTC medications with dosage and frequency):

3. The patient has the following substance abuse issues (if applicable):

4. Please describe and any additional concerns (i.e. abnormal lab results, etc.)

5. I have attached a copy of the dated notes from the patient's last visit. ☐ YES ☐ NO