Health Net®

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BEHAVIORAL HEALTH CARE COORDINATION FORM

Behavioral Health Provider: Responsible practice requires coordination of care with other treating professionals and health care delivery systems as clinically appropriate. Consider using this form (or one with comparable information) to send to your client's PCP.

Instructions:

- **Primary Care Physicians (PCPs):** Copy and give this form to members and request they have their behavioral health provider complete the form to communicate the member's treatment updates to you. Include your contact information in the appropriate area below to ensure receipt of this form.
- **Members/Patients**: Give this form to your behavioral health provider to complete and return to your PCP.
- **Behavioral Health Provider**: Complete the appropriate areas of this form to ensure care coordination with the member's PCP, and fax to PCP.
- **Please send all confidential information under confidential cover sheet or letter**.

Name of Patient _____ Patient ID Number _____

PCP or Other Health Care Provider Name/Fax #: _____

Address/Telephone # _____

Current Psychotropic Medications**:** Is patient currently taking psychotropic meds? Yes____ No____
If yes, please list on backside of this form.

Coordination of Care Issues _____

Behavioral Health Practitioner Name/Fax #: _____

Address/Telephone **#** _____

Dear Doctor (PCP): _____ Today's Date_____
The above named patient is receiving behavioral health services.
Current Diagnosis: _____ Date of first Session _____

**Information exchanged for purposes of treatment, payment and health care operations <u>is</u> permitted under the Health Insurance Portability and Accountability Act (HIPAA) even without a member's authorization to do so. However, a member's <u>authorization is required</u> before behavioral health practitioners share psychotherapy notes (session notes kept separate from the medical record that consist of the contents of conversation during a private, group, joint, or family counseling session) which are not included in this form.*

**This information has been disclosed to you from records whose confidentiality is protected by confidentiality provisions of most states' law and applicable federal law. Under such law, you are prohibited from making any further disclosure of these records without the specific written consent of the person to whom they pertain or as otherwise specifically required or permitted by law.*

**Federal regulations (42 CFR 2.1 and 2.2) restrict any use of confidential information to criminally investigate or prosecute alcohol or drug abuse patients.*

Material ID # Y0035_2014_0556 (H0351, H0562, H5439, H5520, H6815) Compliance Approved 02122014

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Please list psychotropic medications currently taken by patient:

MEDICATION	DOSAGE	START DATE	PRESCRIBED BY	REASON

Other information: _____

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