MOLINA HEALTHCARE

Molina Healthcare of Texas

Combined Behavioral Health Provider/Primary Care Provider Communication Form

If you are unsure of the patient's assigned PCP, please contact Molina Healthcare's Provider Service Department at (855) 322-4080 for further assistance. Please update this form annually or when there has been a significant change in the patient's status. A copy should also be faxed to Molina Healthcare at 866-617-4967

The member below is currently receiving services and has consented to share the following information between their PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information:

Member Name:		**DOB:**		**Member ID#**	

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI:

Note: Behavioral Health Providers are required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent.

The below information is the available disclosed information provided by the above patient, if additional information is needed, p21lease contact the appropriate provider.

Section A: (completed by Primary Care Provider)

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

☐ ADHD/Behavior D/O ☐ Anxiety D/O ☐ Adjustment D/O
☐ Bipolar D/O ☐ Depressive D/O ☐ Eating D/O
☐ Substance Abuse ☐ Personality D/O ☐ Psychotic D/O
☐ Developmental Delay ☐ Parent/Child
☐ Other: _____

2. Expected length of treatment:

☒ < 3months ☐ 3-6 months ☐ 6-12 months ☐ > 1 year

3. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

Prescriber:

5. Please describe any special concerns:

Primary Care Provider:
Primary Care Provider Signature:
Provider Name/Site Name:
Address:

Phone:
Fax:
Date this form completed:

Section B: (completed by BH Provider)

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

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

3. The patient has the following BH (MH/SA) issue(s) (current history if applicable):

4. Please describe any special concerns (i.e., include abnormal lab results, treatment compliance and psychosocial concerns)

Behavioral Health Clinician:
Behavioral Health Clinician Signature:
Provider Name/Site Name:
Address:

Phone:
Fax:
Date this form completed: