



# Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

**Health Plan:** Boston Medical Center HealthNet Plan   Network Health   Fallon Community Health Plan   Neighborhood Health Plan   PCC Plan   HNE

The member below is currently receiving services and has consented to share the following information between his/her 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: \_\_\_\_\_

### Section A: (completed by BH Provider)

1. The patient is being treated for the following behavioral health 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescriber: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

4. Please describe any special concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Behavioral Health Clinician: \_\_\_\_\_

Behavioral Health Clinician Signature: \_\_\_\_\_

Provider Name/Site Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Date this form completed: \_\_\_\_\_

### Section B: (completed by Primary Care 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) problem(s) (if applicable):

\_\_\_\_\_  
\_\_\_\_\_

4. Please describe any special concerns (i.e., include abnormal lab results):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Primary Care Provider Signature: \_\_\_\_\_

Provider Name/Site Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Date this form completed: \_\_\_\_\_

To make a referral to Care Management, please call the members' plan at:

**Boston Medical Center HealthNet Plan: (866) 444-5155 • Network Health: (888) 257-1986 • Fallon Community Health Plan: (888) 421-8861  
Neighborhood Health Plan: (800) 414-2820 • Primary Care Clinician Plan: (617) 790-5633 • Health New England: (617) 790-5633**