ambetter. of Alabama | Insured by Celtic Insurance Company

PRIMARY CARE PROVIDER (PCP)/ BEHAVIORAL HEALTH (BH) PROVIDER COMMUNICATION FORM

In an effort to increase communication and promote care coordination between providers, we ask that you please review and complete the following information.

Member Name: _____ **DOB:** _____

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 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)*, including over-the-counter (OTC):

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. Please describe any special concerns *(i.e. include abnormal lab results)*:

_____

_____

_____

Primary Care Provider: _____

Address: _____

Phone: _____

Date this form completed: _____

Section B: 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)*, including over-the-counter (OTC):

_____ _____

_____ _____

_____ _____

Prescriber: _____

3. Please describe any special concerns *(i.e. include abnormal lab results)*:

_____

_____

_____

Primary Care Provider: _____

Address: _____

Phone: _____

Date this form completed: _____

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