Combined MCE Behavioral Health Provider/ Primary Care Provider Communication Form

Health Plan: Molina Healthcare of Wisconsin

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#:_____ 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)	Section B: (completed by Primary Care Provider)
1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)	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) Prescriber:_____	2. The patient is taking the following medication(s): (list all prescribed andOTC medications, with dosage and frequency as applicable)
3. The patient has the following Substance Abuse problem(s) (if applicable):	3. The patient has the following BH (MH/SA) problem(s) (if applicable):
4. Please describe any special concerns:	4. Please describe any special concerns (i.e., include abnormal lab results):
Behavioral Health Clinician:	Primary Care Provider:
Behavioral Health Clinician Signature:	Primary Care Proficer Signature:
Provider Name/Site Name:	Provider Name/Site Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:
Date this form completed:	Date this form completed: