Member Name ____ Date of Birth _________

ValueOptions Behavioral Health Provider/Primary Care Physician Communication Form (Contact: 877- 564-8517 to reach VO; Fax: 877-755-0334)

Member Consent to Exchange Information (to be completed by member) Health Plan: ___________

I, ______________________________, authorize/do not authorize ______________________________________,
(Please Print) **(Circle one)** **(Provider's Name)**

I can be reached at the following telephone number(s): ____________________ or _________________________.

My behavioral health provider, and ________________________, ____________________________________
(Primary Care Physician Name) **(PCP Address and Phone Number)**
to exchange information regarding my mental health /substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

____ ______________________
I Authorize Communication between My PCP and Behavioral Health Provider (Member's Signature) Date

____ ______________________
I Do Not Authorize Communication between My PCP and Behavioral Health Provider (Member's Signature) Date

____ ______________________
Signature of parent or guardian (if member is a minor) or DPOA Date

____ ______________________
Witness Date

Provider Information (to be completed by Primary Care Physician) - Please Print

____
Physician Name(s) Address City/State Telephone #

Reason for Referral / Comments: ____

____

Medical History: ____

____

Current Medication(s): ____

____

Prescribed Behavioral Health Medication (s):____

____

____ __________________________
PCP /Affiliate Provider Signature/Credentials **Date**

Fax a copy of this form to VO at 877-755-0334, Retaining the original in the patient's chart. Attach confirmation that fax was sent. VO will forward this completed form to the Behavioral Health Provider.

__________ _________________________ _________________/ ______________
Date Sent **Sent By** ***(PCP Office / Staff Initials)*** **PCP Phone** **Fax#**

VO to Fax to Originating PCP Office and attach to CareConnect

ValueOptions PCP doc9/17/ 01
Revised 2/14/2011

Please File in Member's Record

Member Name ____ Date of Birth _________

ValueOptions Behavioral Health Provider/Primary Care Physician Communication Form (Contact: 877- 564-8517 to reach VO; Fax: 877-755-0334)

Behavioral Health Provider Appointment To Be Completed By ValueOptions

Provider Name ____ Provider ID # __________

Provider Address ____ Tele#_________________

Appt Date ____________________ Appt Time: _____________ Appt Kept: Yes___ No___

If No, Contact with Member Yes___ No___ Rescheduled Date __________ Rescheduled Time ________

Comments: ____

____

____

____

____

Updated Member's Telephone # (If Available): ___________________________

Release of Information Completed by Member and Transmitted to ValueOptions:

Yes___ (If Yes, Date Received ____/____/___) No___

☐ Check Box to Confirm Release of Information and Info Sent to Behavioral Health Provider and Attached to VO CareConnect Case

Date Sent ________ Fax # _____________ Office# _____________

ValueOptions Contact ____ Tele # ________________

Clinical Support or Clinical Care Manager

☐ Check Box to Confirm: circle the following; Health Plan Affiliate/Network Provider, Health Plan Clinic Team is made aware of appt.

Date ________ Staff Name ____________________ Tele# _____________

Please File in Member's Record

VO to Fax to Behavioral Health Provider and Attach to CareConnect

Member Name ____ Date of Birth _________

ValueOptions Behavioral Health Provider/Primary Care Physician Communication Form (Contact: 877- 564-8517 to reach VO; Fax: 877-755-0334)

Provider Information (to be completed by *ValueOptions* provider) - Please Print

____

Practitioner Name(s) Facility Name Address City/State

Telephone Number __________________________ Credentials ___________________________
(Therapist and Psychiatrist if applicable)

DSM IV Diagnosis code & name ____

Treatment Plan: Type_______________ Frequency___________ Est length of Tx __________________
(I.e. ind, family, group, meds) (i.e. weekly, etc)

Medication(s)
Prescribed:____

____

Findings / Comments:____

____

____

____

Updated Member's Telephone # (If Available): ___________________________

For urgent or emergency situation, please call the primary care physician in addition to sending form

- ❑ Conclusion of mental health/substance treatment
- ❑ Date of last session _______________ Treatment completed? Yes___ No___
- ❑ Notification of prescription or change in medications (see comments)
- ❑ Other:____

____

Print Clinician Name **Signature/Credentials** **Telephone Number**

A copy of this form must be sent to the primary care physician, retaining the original in the member's chart. If the form is sent by fax, attach confirmation that fax was sent. Fax number is 877-755-0334.

__________ _______________
DATE SENT **SENT BY (BH CLINICIAN INITIALS)**

Please Check Method
Fax ☐ 877-755-0334 Mail ☐

ValueOptions – Medical Coordination
48561 Alpha Drive, Suite #150
Wixom, MI 48393

ValueOptions PCP doc9/17/ 01
Revised 2/14/2011

Please File in Member's Record