PM FORM 4.3.1
COMMUNICATION DOCUMENT

Date:
To: (Primary Care Provider- PCP) Name:
Address:
Phone #:
Fax #:

Dear Care Provider:
The following information is being provided to you for clinical coordination of care purposes. The Information provided to us indicates that you are the assigned AHCCCS Health Plan, Primary Care Provider (PCP) or Medicare provider for this person, although you may not have seen this patient yet. If you would like to have more information, or need to discuss the care and treatment of this patient, please contact the assigned behavioral health care provider listed below in section IV.

RE: Patient Name:
Patient Date of Birth:

AHCCCS ID#:
AHCCCS Health Plan Name:
Medicare Claim #:
Medicare Advantage Plan Name:

I. REASON FOR THIS COMMUNICATION: (Check applicable reason(s))

- ☐ Person referred by AHCCCS Health Plan/PCP/Medicare Provider
- ☐ Person determined to be Seriously Mentally Ill (SMI)
- ☐ Information regarding person was specifically requested by the AHCCCS Health Plan/PCP or Medicare Provider
- ☐ Annual Notification
- ☐ Person has Pervasive Development Disorders and/or Developmental Disabilities
- ☐ Other (Please specify):

II. CLINICAL SUMMARY

A) Required Information (for PCP referral or SMI enrollee)

1) DSM-IV Diagnosis:
   Axis I:
   Axis II:
   Axis III:

2) Current medications prescribed for behavioral health treatment (dose and frequency)

3) Other attached information (Required only if requested by PCP, otherwise optional)
   - ☐ Behavioral Health Assessment (Date):
   - ☐ Individual Service Plan (Date):
   - ☐ Results of laboratory, radiology or other tests (Date):
   - ☐ Other (Please specify):

III. RESPONSE TO PCP'S REFERRAL QUESTION(s):

IV. CONTACT INFORMATION

FROM: T/RBHA Name:
Provider Agency Name:
Provider Agency Address:
Provider Agency Phone #:
Provider Agency Fax #:
Psychiatrist, Nurse Practitioner, Physician Assistant Name:
Psychiatrist, Nurse Practitioner, Physician Assistant Phone #:
Clinical Liaison Name:
Phone #:
Other Contact Name:
Phone #:
Date PCP Referral from the Health Plan was received (If applicable):

☐ Mailed ☐ Faxed By (Print name):

Signature _____ Date:

Note: Retain copy in person's comprehensive clinical record.

Effective Date: 12/01/2007
Last Revised: 07/19/2007