BlueCross BlueShield of Montana

Coordination of Care Form

The Blue Cross and Blue Shield of Montana Behavioral Health Care Management program continually strives to promote coordination of member care between medical and behavioral health providers. However, we understand that one of the most difficult challenges for providers today is communicating with other providers regarding a patient's treatment to ensure care is appropriately coordinated. In order to assist you in the process, we are making available to you the Coordination of Care Form which can be an optional tool in your practice if you do not already have an effective method of communication.

This form is in PDF format and may not open properly if you do not have this program available to you. Click on this link to download the application: http://get.adobe.com/reader/

This form can be used to:

- Provide member treatment information ***to*** another treating provider
- Request member treatment information ***from*** another treating provider

Helpful Hint:

If you are requesting information from another provider, we suggest completing the Patient Information and Referring Provider sections on the ***Coordination of Care Form*** in order to expedite the process for the receiving provider.

Please Remember:

It is important at the onset of treatment to obtain a written release to share clinical information with the member's medical provider(s). Be sure to keep this in mind and follow the applicable state regulations regarding the release of protected health information (PHI) and sensitive personal information (SPI).

We hope this form will be useful to you in coordinating member care.

Please let us know if you have any suggestions on how we can improve this form by emailing us at BHQualityImprovement@bcbstx.com.

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Email or fax the completed form to inform or seek information from another provider.

Patient Information			
Patient's Name:		Patient's Date of Birth (MM/DD/YYYY):	
Member Identification Number:			
Provider Information			
Name of Provider:		Address:	
Telephone Number:		Fax Number:	
Clinical Information			
Treatment Date(s):		Next Appointment Date (MM/DD/YYYY):	
Diagnosis/Medications:			
Presenting Symptoms:			
Treatment Plan/ Recommendation:			
Additional Comments:			

Provider Signature

Date

Appropriate, signed release of information form is on file.