



BEHAVIORAL / PHYSICAL HEALTH COORDINATION

State Form 51856 (R / 9-04) / OMPP 0016

Family & Social Services Administration
Office of Medicaid Policy & Planning

IMPORTANT (PLEASE READ): This form may contain protected health information from the INDIANA HEALTH COVERAGE PROGRAMS (IHCP), which is intended only for the use of the individual or entity named in this form. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure or reproduction of this information is prohibited. Any unintended recipient should contact the sender immediately.

Insurer/patient identification number CLIENTS INFO		Date (month, day, year) — DATE —	
Name of member 1		Date of birth (month, day, year) CLIENT INFO	
Health care provider PRIMARY CARE DOCTORS INFO		Behavioral health provider Hope Haven Psychological Resource, LLC	
Address (number and street)		Address (number and street) 5610 Crawfordsville Road, Suite 701	
City, state, ZIP code		City, state, ZIP code Indianapolis, Indiana 46224	
Telephone number ()	Fax number (1)	Telephone number (317) 241-4673	Fax number (317) 241-0201

This form was filled out by
self and Hope Haven Psychological Resource, LLC

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate health care professional.

More information: www.indianamedicaid.com

PATIENT CONSENT

Please check if you **DO NOT** want the following protected health information released: Behavioral Health Substance Abuse HIV/AIDS

This authorization will expire on **PLEASE ALLOW TWO (2) YEARS FROM TODAY**. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by Hope Haven Psychological Resource will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed

Name of provider

Signature of member **SIGN HERE IF AGREE**

by the recipient and may no longer be protected.

Signature of member **SIGN HERE IF DECLINE**

Member declined to participate

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING

Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			-----
2.			Current diagnosis:
3.			-----
4.			Comments:
5.			-----
6.			-----

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING

Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			-----
2.			Current diagnosis:
3.			-----
4.			Comments:
5.			-----
6.			-----

Please provide the following information regarding (Member name)	2. Is another appointment required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date and time scheduled <input type="checkbox"/> AM <input type="checkbox"/> PM
1. Results of appointment, including any prescriptions ordered (attach forms as necessary)	3. Are there any special instructions for this member to follow? (please describe)	