INLAND EMPIRE HEALTH PLAN

Behavioral/Mental Health Coordination of Medical Care Form

PLEASE FAX TO: IEHP Fax: (909) 890-2999 **IEHP PHONE: (909) 890-2000**

Request Date: ______________ Requested by: (print Clinician's name) ______________

Phone Number: (   ) ______________ Fax Number: ______________

☐ Medi-Cal ☐ Healthy Families ☐ Healthy Kids ☐ Medicare

Member Name: ______________ Member/IEHP ID#: ______________

Address: ______________ DOB: ______________

City: ______________ Primary Phone #: (   ) ______________

Parent/Guardian Name: ______________ Secondary Phone #: (   ) ______________

Current Medical/Psychiatric Condition/Medication: ______________

Reason for referral: Suspected Diagnosis: ______________

☐ Primary Care Physicians to Mental Health
a. Psychiatric Evaluation and Treatment
b. ADD/ADHD Diagnosis Evaluation

☐ Mental Health Provider to Primary Care Physician
a. Medical Evaluation and Treatment
b. Psychiatric Medication Management **

** Must include discharge summary with Psycho/Social Information, 5 Axis Diagnosis, Current Medications

☐ Other:

Clinician's Signature Date

For Psychiatric Medication Management by PCP, indicate contact information for follow-up PCP consultations:
Clinician (print name): Phone #: (   )

"I hereby authorize my physician, health care practitioner, mental health provider, hospital, clinic or other medical or medically related facility to furnish to IEHP, or its designated parties, any and all records pertaining to my medical history, including services rendered or treatment received. I understand that this information may be disclosed for the purpose of investigation, review, or evaluation of a grievance, complaint or claim or other use. I understand my right to retain a copy of this release/authorization. This authorization shall remain effective as long as my grievance, complaint or claim is being processed, but for not longer than one (1) year from the date signed below."

Patient/Guardian Signature: ______________

IEHP USE ONLY

Referral Notes: ______________

Provider: ______________ Provider Phone #: (   ) ______________ IPA Affiliation: ______________

Fax: #: (   ) CM Signature:

* Disclaimer: Authorization for services are valid only if member is enrolled and eligible for coverage by Inland Empire Health Plan on the date services are provided. To check eligibility call 1-888-440-4340.

(Revision Date 02/20/04)