PRIMARY HEALTH CARE EXCHANGE OF INFORMATION REQUEST
Medi-Cal Managed Care Program

This form is used for the purpose of exchanging practitioner and beneficiary information to enhance care coordination for Medi-Cal Managed Care beneficiaries.

BENEFICIARY INFORMATION

Name: _____ **DOB:** _____

Address: _____ **City:** _____ **Zip:** _____ **Telephone:** _____

SSN: _____ ☐ **Medi-Cal #:** _____

PRIMARY CARE PRACTITIONER (PCP) *– INITIATING QUERY OR COORDINATION OF CARE*

Practitioner's Name: _____ **Telephone:** _____ **FAX:** _____

Email: _____ **Date of Last Visit:** _____

Physical Diagnosis(es): _____

Current Medications: _____

Reason(s) for Request:

☐ Depression or anxiety symptoms not responding to therapy ☐ Suspected Pediatric ADHD ☐ Suspected Psychosis
☐ Suspected Mood Disorder ☐ Coordination of Care ☐ Suspected Substance Abuse
☐ Other _____

_____

Practitioner's Signature: _____ **Date:** _____

Ask the beneficiary to sign the Agreement for Information Exchange at the bottom of the form. After making a copy of the form for your records, give the original to the beneficiary to take to the Behavioral Health Practitioner (BHP) who will complete the response portion and return the form to you. Send results of CBC, LFTs, TFTs, U/A, EKG, and any relevant consults, procedure results, or information with your request.

BEHAVIORAL HEALTH PRACTITIONER RESPONDING TO REQUEST

The PCP initiating this form is requesting behavioral health information for the above named person. Please complete and return this form via the beneficiary or by faxing to the PCP.

BHP Name: _____ **Telephone:** _____ **FAX:** _____

Diagnosis(es): _____ **Date of Last Visit:** _____ **Email:** _____

Current Medications: _____

_____

Recommendations or Response to the Request (attach information if necessary): _____

_____

Practitioner's Signature: _____ **Date:** _____