DRAFT PM FORM 4.3.2
REQUEST FOR INFORMATION FROM PCP OR MEDICARE PLAN/PROVIDER
Magellan Health Services of Arizona Edition

TO:
PCP/Medicare Plan/Provider Name:

Address:
Phone #:
Fax #:

FROM:
Behavioral Health Provider Name:

Address:
Phone #:
Fax #:
Contact Name:
Contact Phone #:
Contact Title:

Dear PCP or Medicare Plan/Provider:
The above behavioral health provider is writing to request information that concerns one of your patients for the purpose of coordinating care. The quality of care that this person receives is dependent on your timely response to this request. **Confidentiality laws do not require a separate authorization to release this information. (Protected health information pertaining to alcohol, drug and HIV/communicable disease information requires separate authorization according to A.R.S. § 36-664 and 42 CFR Part 2. For more information see PM Section 4.1 Disclosure of Behavioral Health Information.)** If you have questions regarding this request, please contact the above referenced person.

RE: Patient Name:
Patient Date of Birth:

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

Please send the following information regarding this patient:

☐ Mailed ☐ Faxed By (Print name):

_____ Date:
Signature

Note: Retain copy in person's comprehensive clinical record

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