Joseph E. Kernan, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

October 1, 2004

Dear Medicaid Provider:

In 2004 a multidisciplinary group consisting of mental health advocates, managed care organizations, primary health care providers, the community mental health system, academics, and state officials met to discuss methods for improving the communication between behavioral health and physical health providers.

The group began with the belief that the exchange of information between physical and behavioral healthcare providers is essential for safe, effective coordination of care. The result is the attached form – **The Behavioral/Physical Health Coordination Form**. It is our hope that you will use the form to assist in the sharing of information, thus increasing the coordination of care between the two health care systems.

The purpose of this letter is to address HIPAA and other privacy laws that may concern you, as they relate to using the form. Both HIPAA (45 CFR Part 164.501, .502, and .506) and state law (IC 16-39-2-6(a)(1)) permit the flow of patient information between providers as is necessary to coordinate and manage the provision health care, even without patient authorization. While patient consent is always desirable to obtain, lack of patient consent is only a legal concern if the provider is a federally assisted alcohol or drug program, since 42 CFR Part 2.51 requires the existence of a medical emergency before an unconsented disclosures between providers can be made.

With the information above in mind, we encourage you to utilize the attached form to promote the exchange of relevant healthcare information between behavioral and physical health care providers serving the same patient. You'll note the form contains a patient authorization that is good practice to obtain but is necessary only as noted above.

This form is also available on the web sites for Hoosier Healthwise (www.healthcareforhoosiers.com), *Medicaid Select* (www.medicaidselect.com), and the Indiana Health Coverage Programs (www.indianamedicaid.com).

Thank you in advance for your willingness to provide the necessary information to better coordinate the health care of our shared patients.

Sincerely,

Melanie Bella
Assistant Secretary
Office of Medicaid Policy and Planning

Stephen C. McCaffrey, JD
President and Chief Executive Officer
Mental Health Association in Indiana

MEDICAID BEHAVIORAL / PHYSICAL HEALTH COORDINATION

State Form 51856 (8-04) / 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.

	Date (*month, day, year*)
Name of member	Date of birth (*month, day, year*)
Health care provider	Behavioral health provider
Address (*number and street*)	Address (*number and street*)
City, state, ZIP code	City, state, ZIP code
Telephone number ( ) / Fax number ( )	Telephone number ( ) / Fax number ( )
This form was filled out by	

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 _____ (Date (*month, day, year*)). 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 _____ (Name of provider) will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Signature of member

☐ **Member declined to participate**

Signature of member

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? ☐ Yes ☐ No	If yes, date and time scheduled ☐ AM ☐ 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*)	