COMMUNITY FIRST HEALTH PLANS

Provider Communication Form (Confidential)

Continuity and Coordination of Care

I, _____ , provide health care services for the Community First Health Plans Member named below.
Provider Name

I have included all treatment information related to this patient in an effort to provide continuity and coordination of care.

MEMBER INFORMATION

Member Name: _____ Member ID #: _____

Member DOB (MM/DD/YYYY): _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

The patient is being treated for the following health problems (please list all diagnoses):

DIAGNOSIS	NOTES

The patient is taking the following prescribed medication(s):

MEDICATION NAME	DOSAGE	FREQUENCY	START DATE – END DATE	SIDE EFFECTS

Please select the purpose of this communication:

- ☐ Initial Evaluation
- ☐ Routine Update
- ☐ Service Termination
- ☐ Medication Change
- ☐ Safety Concern
- ☐ Recent Hospital Stay
- ☐ Non-adherence Treatment Plan/Med Regime
- ☐ Prevention Screening (Mammogram Colonoscopy/Cervical Cancer Screening/ Immunizations)
- ☐ Other:

Comments:

Consent form attached: ☐ YES ☐ NO

Supporting documentation attached: ☐ YES ☐ NO

Provider Name:

Group Name:

Address:

Phone: Fax:

Provider Signature

Date