PCP Coordination of Care

To: ______________________________ Date: _____________

From: ______________________________

Address: ______________________________

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Re: Coordination of Care for _________________________________,

Medicaid ID number_________________ Date of birth____________.

Dear Primary Care Provider (PCP),
I am a contracted mental health provider with Foothills Behavioral Health (FBH), the Behavioral Health Organization (BHO) that contracts with the State of Colorado to arrange and reimburse for mental health services for individuals who are Medicaid eligible and reside in Boulder, Broomfield, Clear Creek, Gilpin or Jefferson Counties.

Per the enclosed Release of Information, I have the patient's/parent's or guardian's consent to contact you for the purpose of coordination of care. As you are aware, there is clear evidence that supports the value of, and improved outcomes of addressing the physical and behavioral health needs from an integrated perspective. The enclosed signed release authorizes your office to release information that you believe will be helpful in supporting my efforts to treat the behavioral health issues.

At present, I am providing ongoing mental health services consisting of __________________

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for the treatment of (diagnosis) ____.

If this patient is 20 years of age or under, please send the most recent results of the well-child check-ups and related information that might be of assistance in my treatment planning.

If you would like to receive additional information related to the services that I am providing or about how the client is responding, please feel free to have your office contact me by telephone at _____________________ or by email at ____. I look forward to working with you in the effort to enhance the delivery of care.

Sincerely,

Provider Use Only: ☐ This Medicaid Consumer does not have a current PCP and was referred to FBH at 303-432-5958 or www.chcpf.state.co.us/HCPF/Providers/ProviderIndex.html for a PCP referral.

05/07