MH 707
Revised 10/28/14

CARE COORDINATION BETWEEN PROVIDERS

☐ Request for Information ☐ Providing Information

CLIENT

Name: _____ Medi-Cal CIN:_____ DOB: _____

Address: _____ Phone Number: _____

Gender: _____ Client's Preferred Language: _____

Caregiver's Name (if appropriate): _____ Caregiver's Preferred Language: _____

Payor Source: ☐ Medi-Cal Only ☐ Medicare Only ☐ Medi-Medi ☐ Uninsured ☐ Other _____

SENDER

Agency: _____

Contact Person: _____

Phone Number: _____

Fax Number: _____

E-Mail: _____

Affiliation: ☐ DMH (Directly Operated) ☐ DMH (Contract Agency)
☐ DHS ☐ LACare (health) ☐ Beacon (behavioral health) ☐ Kaiser
☐ HealthNet(health) ☐MHN(behavioral health) ☐ Molina ☐ Anthem
☐ Care1st ☐ CareMore ☐ SAPC ☐ Other _____
☐ Unknown For Health Plans/Agencies, MR#_____

RECIPIENT

Agency: _____

Contact Person: _____

Phone Number: _____

Fax Number: _____

E-Mail: _____

Affiliation: ☐ DMH (Directly Operated) ☐ DMH (Contract Agency)
☐ DHS ☐ LACare (health) ☐ Beacon (behavioral health) ☐ Kaiser
☐ HealthNet(health) ☐MHN(behavioral health) ☐ Molina ☐ Anthem
☐ Care1st ☐ CareMore ☐ SAPC ☐ Other _____
☐ Unknown

PURPOSE OF INFORMATION *(Check as many boxes as applicable)*

☐ Referral ☐ Transfer ☐ Discharge ☐ Coordination ☐ Recommendation ☐ Consultation ☐ Change in Level of Care
☐ Other _____

INFORMATION REQUESTED/PROVIDED ☐ on form ☐ attached ☐ faxed: Date _____ Time_____

(Check as many boxes as applicable.) ☐ Assessment Summary ☐ Treatment Plan ☐ Discharge Plan ☐ Diagnosis
☐ Medications ☐ Treatment Information ☐ Laboratory (specify) _____ ☐ Other (specify) _____
Comments: _____
_____
_____

SIGNATURES

Name of Rendering Provider: _____ Title: _____

Contact Information (if different from Sender information above): _____

Signature: _____ Date: _____

ABSENCE OF MEDICAL NECESSITY FOR SPECIALTY MENTAL HEALTH SERVICES (Only complete if applicable)

Date Medical Necessity Determined Absent: _____ Rendering Provider's Supervisor Name _____

Contact Information (if different from Sender information above): _____

Signature: _____ Date: _____

DMH USE ONLY

Name: **IS/IBHIS#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

Original Copy – Receiving Agency
Copy – Initiating Agency

CARE COORDINATION BETWEEN PROVIDERS

CARE COORDINATION BETWEEN PROVIDERS

Purpose: This form is for use by mental health/health/substance use providers when requesting information from or providing information to other health/mental health/substance use providers for purposes such as transferring, coordinating care, or responding back to a referral.

Completion Instructions: (All sections are to be completed by the provider initiating the form)

On the top of the form, select if this is a "Request for Information" or "Providing Information"

Client:
- Fill-in the specific client information requested on the form.
- If appropriate, enter in the caregiver's name and preferred language. These fields are not required to be completed.
- Payor Source: only one box should be checked; if "Other" is checked, fill in the specific payor source information.

Sender:
- The person completing the form should fill in their information as requested on the form.
- Under "Affiliation", select the most appropriate entity overseeing the Sender's agency.
- For Health Plans/Agencies, there is an optional field for entering in a Medical Record (MR) number.

Recipient:
- The person completing the form (Sender) should complete the information for who the form is intended to be sent (Recipient).
- Under "Affiliation", select the most appropriate entity overseeing the Recipient's agency. Select "unknown" if the overseeing entity for the Recipient is not known. Note: SAPC stands for the Department of Public Health Substance Abuse Prevention & Control.

Purpose of Information:
- Check off the purpose of the form. Multiple boxes may be checked. If "Other" is checked, please specify.

Information Requested/Provided:
- Identify if the information requested/provided is on the form and/or attached to the form and/or faxed. If faxed, identify the date and time the document(s) was faxed.
- Check off the information that is being requested or provided. Multiple boxes may be checked and additional comments may be provided. If "Laboratory" is checked, please identify the types of labs. If "Other" is checked, please specify.

Signatures:
- If information is being provided on the form and/or the absence of medical necessity was determined, the Rendering Provider information must be completed.
- If the Rendering Provider's contact information is different from the contact information identified under "Sender", enter in the Rendering Provider's contact information.

Absence of Medical Necessity For Specialty Mental Health Services:
- If this form is being used to notify the recipient that the client does not meet medical necessity criteria for Specialty Mental Health Services, enter the date this was determined.
- The Rendering Provider's supervisor must then sign the form and provide contact information (if different from the contact information identified under "Sender").

NOTE: Sharing information must comply with all HIPAA rules. DMH Directly Operated staff should refer to DMH Policy & Procedures related to HIPAA Privacy. Other providers should refer to their own legal counsel and policies.

Filing Procedures for DMH:
- Paper Chart: File chronologically in Section 2 Correspondence of the Clinical Record
- IBHIS: Scan into the Correspondence folder.