PASSPORT HEALTH PLAN

BEHAVIORAL HEALTH LIAISON REQUEST FORM

MEMBER INFORMATION

MEMBER'S NAME _____ PHONE # _____

PASSPORT ID _____ MEMBER'S DOB _____

ADDRESS _____

REASON FOR REFERRAL

- ☐ Help member select a provider for Behavioral Health Services
- ☐ Assist member with follow up to Behavioral Health Provider

INDICATORS FOR REFERRAL (CHECK ALL THAT APPLY)

- ☐ Suicidal/homicidal ideation or behavior
- ☐ At-risk of hospitalization due to behavioral health condition
- ☐ Child at imminent risk of out-of-home placement in a psychiatric hospital, PRTF, or treatment foster care placement
- ☐ Trauma victims including possible abused or neglected member
- ☐ Request by member, parent, or legal guardian
- ☐ Clinical status that suggests the need for behavioral health services
- ☐ Identified psychosocial stressors
- ☐ Treatment compliance complicated by behavioral characteristics
- ☐ Behavioral, psychiatric, and/or substance abuse factors influencing a medical condition
- ☐ Non-medical management of substance abuse
- ☐ Follow-up to medical detoxification
- ☐ Initial PCP contact or physical indicates a substance abuse or mental health problem
- ☐ A prenatal visit indicates a substance abuse or mental health problem
- ☐ A pattern of inappropriate use of medical, surgical, trauma, or urgent care or ER services that could be related to substance abuse or other behavioral health condition
- ☐ Other: _____

PROVIDER INFORMATION

PHYSICIAN NAME _____ PHONE # _____

ADDRESS _____

Please send completed form to:
Care Coordination Department
877-903-0082 (phone)
502-585-7997 (fax)