

Clinician Collaboration Form

Patient name _____ DOB: _____

Has the *Authorization to Release Information Form* been completed and documented in the patient's chart?

Yes ____ No ____

Reason for collaboration:

I am referring or following the above-named patient for _____

Diagnosis: _____

Related medical history: _____

Current medications: _____

Lab information

Labs completed: _____

Labs needed: _____

Additional information: _____

Suggestions for care/Identified needs: _____

Physician/Practice name: _____

Phone number: _____ Fax: _____

Email: _____

Signature of person completing form: _____ Date: _____

Magellan Healthcare, Inc., an independent company, manages mental health and substance abuse benefits for most Independence Blue Cross members.

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.