Independence

Magellan HEALTHCARE

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:

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Lab information

Labs completed: ____

Labs needed: ____

Additional information:

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Suggestions for care/Identified needs:

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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.