Client has a PCP ❑ Yes ❑No

❑ Refused to provide PCP information

Date: ______________________

Client's Name: ____

Date of Birth: _______________________________ Medicaid No.: ___________________________

Primary Care Physician ________________________

PCP Address and or Phone Number ____

Dear Dr. ________________________________

The following is supplied for your information regarding the above client:

Beginning date of treatment ________________ Diagnosis _______________________________________

Treatment plan/treatment team:

Current Medications: ___________________

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Mental Health Clinician/Psychiatrist: _______________________________

Mental Health Clinician's Phone or Contact Information: ________________________________

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Number to call if client needs a PCP: 303-839-2120 for Denver Metro, or 1/888/367/6557 in all other areas,

BHI Form #129E (09/06)