



# Best Practice Network PCP Medical Record Update

## Type of Service

- Behavioral Health
- Specialist
- Dental
- Health Department

Patient Name: \_\_\_\_\_

Enrollee ID No.: \_\_\_\_\_

## Consulting Provider Information

Name: \_\_\_\_\_

Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Fax No.: \_\_\_\_\_

## Patient Care Information

Date(s) of Visit(s): \_\_\_\_\_

Primary Diagnosis or ICD-9: \_\_\_\_\_

Secondary Diagnosis or ICD-9: \_\_\_\_\_

Diagnostic (including lab, imaging, etc.) and therapeutic services provided: \_\_\_\_\_

\_\_\_\_\_

Is the primary (referral) condition resolved?  Yes  No (If no, comment on treatment plan)

## Follow-up Care

Date: \_\_\_\_\_  This Office  PCP  Another Practitioner: \_\_\_\_\_

Recommendations / Comments: (Attach additional pages if necessary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

EPSDT Components (Please indicate if any of the following were performed):	
<input type="checkbox"/> Comprehensive Health and Developmental History <input type="checkbox"/> Comprehensive Unclothed Physical Exam <input type="checkbox"/> Health Education <input type="checkbox"/> Vision Screening <input type="checkbox"/> Hearing Screening <input type="checkbox"/> Dental Screening and Referral	<input type="checkbox"/> Immunizations <small>(please check any given)</small> <input type="checkbox"/> HepB <input type="checkbox"/> DTaP <input type="checkbox"/> HIB <input type="checkbox"/> IPV <input type="checkbox"/> PCV <input type="checkbox"/> MMR <input type="checkbox"/> VZV <input type="checkbox"/> HepA <input type="checkbox"/> Other
<input type="checkbox"/> Laboratory Tests <small>(please indicate lab test(s) conducted)</small> <input type="checkbox"/> Hematocrit <input type="checkbox"/> Blood Lead Level <input type="checkbox"/> TB <input type="checkbox"/> Other <small>(please indicate)</small> _____	

Mail or fax to Primary Care Practitioner at:
<b>Name:</b> _____ <small>(Please Print)</small>
<b>Address:</b> _____ _____ _____
<b>Fax No.:</b> _____
<b>Reviewed by PCP (Initial)</b> _____

## Instructions

Participation in the Best Practice Network (BPN) requires that the BPN PCP maintain all the health records of the BPN member (medical and behavioral), regardless of where care is provided. The BPN PCP Medical Record Update form may be used to facilitate this comprehensive medical record.

The form should be completed by Behavioral Health Providers, Dentists, Medical Specialists and Health Departments whenever they see a BPN Member and forwarded to the BPN PCP shown on the member's ID card. Communication of information to the PCP could be either through the use of this form or through the use of a letter that contains all of the requested information on the BPN PCP Medical Record Update.

**Note: Best Practice Network (BPN) requires that the PCP initial this *BPN PCP Medical Record Update* form as confirmation of review.**

**Type of Service** Enter a check mark beside the appropriate service type.

**Patient Name:** Provide us with the name shown on the ID card.

**Enrollee ID Number:** Indicate the TennCare<sup>SM</sup> ID number of the patient.

**Consulting Provider Information** Your name, address, telephone and fax number.

**Patient Care Information** Provide all dates of service, primary and secondary diagnosis, any treatment and/or diagnostic labs obtained; whether or not there was a resolution of care; follow-up visits indicated with you, another consultant/specialist or PCP.

**EPSDT Screening Components** Indicate with a check mark any of the screenings performed at this visit for the patient.

**Form must be faxed or mailed to PCP at initial visit of patient and post discharge of patient.**

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