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| **HSTAR\_PA Part C: Care Coordination Information**  To be submitted with the HSTAR\_PA form upon initial request,  and with subsequent requests as there are changes | | |
| **Member information** | | |
| Member Full Name: | | Member Medicaid ID: |
| **Primary Care Provider** | | |
| PCP Name: | Contact Info: | |
| Has Care been Coordinated with this provider?  Yes  No  If no, why not? | | |
| **Dental Provider** | | |
| Dentist Name: | Contact Info: | |
| Has Care been Coordinated with this provider?  Yes  No  If no, why not? | | |
| **Other Mental Health or SUD Provider** | | |
| Name: | Contact Info: | |
| Has Care been Coordinated with this provider?  Yes  No  If no, why not? | | |
| **Other Mental Health or SUD Provider** | | |
| Name: | Contact Info: | |
| Has Care been Coordinated with this provider?  Yes  No  If no, why not? | | |
| **Current Medication Prescriber** | | |
| Name: | Contact Info: | |
| Has Care been Coordinated with this provider?  Yes  No  If no, why not? | | |
| Current Medications Prescribed: | | |

Upon completion of this form, please submit, with HSTAR\_PA form and appropriate clinical documentation, to member’s assigned Behavioral Health Plan Partner:

* Clackamas County Behavioral Health – via Fax: (503)742-5355
* Multnomah County Behavioral Health - via Email: [asoc.team@multco.us](mailto:asoc.team@multco.us) or via Fax: (503-988-9383)
* Washington County Behavioral Health – via Fax: (503)846-3522