

**POLICY FORM 902.2**  
**REQUEST FOR INFORMATION FROM PCP OR MEDICARE PLAN/PROVIDER**

**TO:**  
**PCP/Medicare Plan/Provider Name:**

**FROM:**  
**Behavioral Health Provider Name:**

Address:  
Phone #:  
Fax #:

Address:  
Phone #:  
Fax #:  
Contact Name:  
Contact Phone #:  
Contact Title:

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Dear PCP or Medicare Plan/Provider:

The above behavioral health provider is writing to request information that concerns one of your patients for the purpose of coordinating care. The quality of care that this person receives is dependent on your timely response to this request. **Confidentiality laws do not require a separate authorization to release this information. (Protected health information pertaining to alcohol, drug and HIV/communicable disease information requires separate authorization according to [A.R.S. § 36-664](#) and 42 CFR Part 2. For more information see [Policy 1401, Confidentiality.](#))** If you have questions regarding this request, please contact the above referenced person.

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**RE:** Patient Name:  
Patient Date of Birth:

AHCCCS ID#:  
AHCCCS Health Plan Name:  
Medicare Claim #:  
Medicare Advantage Plan Name:

Please send the following information regarding this patient:

Mailed     Faxed    By (Print name):

\_\_\_\_\_  
Signature

Date:

**Note: Retain copy in person's comprehensive clinical record**