Coordination of Care Form/Treatment Summary

AMERIGROUP requires network behavioral healthcare practitioners/providers to coordinate treatment with other providers, primary care practitioners (PCPs) and other appropriate medical practitioners involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

PATIENT'S NAME: **DOB:**

A. BEHAVIORAL HEALTHCARE PRACTITIONER/PROVIDER INFORMATION

NAME: **TELEPHONE:**

B. PCP/MEDICAL PRACTITIONER OR OTHER PRACTITIONER/PROVIDER INFORMATION

NAME: **ADDRESS:**

TELEPHONE: **FAX:**

C. PATIENT CLINICAL INFORMATION

1. The patient is being treated for the following behavioral health diagnosis(es):

2. The patient is taking the following prescribed psychotropic medication(s):

3. The patient is engaged in the following psychotherapeutic intervention(s):

a. Frequency of intervention(s):

4. Coordination of care issues/other significant information impacting medical or behavioral healthcare:

BEHAVIORAL HEALTHCARE PROVIDER SIGNATURE: **DATE:**

FAX OR MAIL FORM TO OTHER PROVIDER: **DATE MAILED OR FAXED:**