providers.amerigroup.com

Coordination of care and treatment summary

In accordance with acceptable medical practice, Amerigroup Iowa, Inc. requires network behavioral health care providers, primary care providers and other appropriate medical providers involved in a member's treatment to coordinate care. Please complete this form and send it to the appropriate provider(s) treating this member after obtaining written patient consent, in compliance with all applicable state and/or federal regulations.

Member name:	Date of birth:
A. Your information	
Name:	Phone:
Practice name:	Address:
B. Other provider information	
Name:	Address:
Phone:	Fax:
C. Member clinical information	
1. I am treating the member for the following diagnosis(es):	
2. The member is taking the following prescribed medication(s) that I have prescribed:	
3. **(For behavioral health providers only)** The member is engaged in the following psychotherapeutic intervention(s):	
Frequency of intervention(s):	
4. Coordination of care issues/other significant information affecting medical or behavioral health care:	
Signature:	Date:
Fax or mail form to [list other provider(s)]:	Date mailed or faxed:

Important Note: You are not permitted to use or disclose protected health information about individuals who you are not currently treating or are not enrolled to your practice. This applies to protected health information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.