Coordination of Care and Treatment Summary

In accordance with acceptable medical practice, Amerigroup 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 other 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) I 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: