Amerigroup
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https://providers.amerigroup.com/DC

Coordination of Care and Treatment Summary

In accordance with acceptable medical practice, Amerigroup District of Columbia, Inc. requires network behavioral health care providers, PCPs 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 the listed member after obtaining written patient consent (in compliance with all applicable state and/or federal regulations).

Member name:	DOB:
A. Provider information	
Name:	Phone #:
Practice name:	Address:
B. Other provider information	
Name:	Address:
Phone #:	Fax #:
C. Member's clinical information	
1. I am treating the member for the following diagnosis(es):	
2. The member is taking the following 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: