ambetter of Tennessee

# Coordination of Care Checklist

**Patient Name:** ______________________ **DOB:** ______________________

**Service and Start Date:** ______________________ **Provider:** ______________________

**Is there a Primary Care Physician?** ☐ Yes ☐ No ☐ Declined

PCP Name: ______________________

Phone #: ______________________ Fax or Email: ______________________

**Release of Information Signed?** ☐ Yes ☐ No ☐ Declined

**Is there another Behavioral Health (BH) Clinician?** ☐ Yes ☐ No ☐ Declined

BH Clinician's Name/License: ______________________

Phone #: ______________________ Fax or Email: ______________________

**Release of Information Signed?** ☐ Yes ☐ No ☐ Declined

**Is there another treatment provider?** ☐ Yes ☐ No ☐ Declined

Provider's Name/License: ______________________

Phone # ______________________ Fax or Email: ______________________

**Release of Information Signed?** ☐ Yes ☐ No ☐ Declined

**Documentation of Contacts and Attempts to Coordinate Care:**

| Date | Provider Contacted | Phone, Fax, Email | Information Shared or Discussed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |



PRO_2144952E Internal Approved 06282023

©Ambetter of Tennessee 2023

2144952_TN3PMKTFRME