

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 #:		
nail:				
Release of Information Signed?		□ Yes	□No	□ Declined
Is there another treatment provider?		□ Yes	□ No	□ Declined
Provider's Name/License:		_ Phone #:		
nail:				
Release of Information Signed?				
of Information Signed?		☐ Yes	□ No	□ Declined
	d Attempts to Co			□ Declined
tion of Contacts and		ordinat	e Care:	
	d Attempts to Co Phone, Fax, Em	ordinat	e Care:	□ Declined ation Shared or Discussed
tion of Contacts and		ordinat	e Care:	
tion of Contacts and		ordinat	e Care:	
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tion of Contacts and		ordinat	e Care:	
	rimary Care Physiciane:	rimary Care Physician? e: nail: of Information Signed? cher Behavioral Health (BH) Clinician? an's Name/License: nail: of Information Signed? ther treatment provider? s Name/License:	e:Phone#: nail: f Information Signed?	rimary Care Physician? e:

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