



FROM



peach state health plan™

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

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