missouricare
A WellCare Company

Coordination of Care Form

Behavioral health providers are asked to complete the form and send to the member's PCP for inclusion in the medical record. Providers may access the form on our website at www.missouricare.com

CONFIDENTIAL: REPORT TO PROVIDER			**Report Date**
To	Provider/Center Name		
	Address		
	City, State ZIP		
	Phone	Fax	
From	Provider/Center Name		
	Address		
	City, State ZIP		
	Phone	Fax	
Member Information	ID #		
	Last Name		
	First Name		
	Date of Birth		
Date of Initial Visit	☐ Initial Report ☐ Interim Report ☐ Termination Report		
Presenting Problem			
Treatment Plan/Recommendation			
Medications			
Axis I:	Axis II:		
Axis III:	Axis IV:		
Axis V:	ICD-9DX		
Provider Signature		**Patient Signature**	

This form is considered confidential.