UnitedHealthcare Community Plan
Coordination of Care Summary form

To be used as a communication tool between health professionals (PCPs, specialist, mental health and substance abuse providers) treating UnitedHealthcare Community Plan members to ensure comprehensive care.

Member Name & ID: _____
Or Member Representative: _____
Relationship to Member: _____
Member DOB: _____

Member Contact info: _____
Member Rep. Contact info: _____

Treating Professional: _____
Treating Prof. Contact info: _____
(with discipline)

Reason for visit:

_____
_____
_____
_____
_____

Diagnosis:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Medications:

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

Other Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Form sent to:
Provider Name: _____
Provider Specialty: _____
Provider Contact info: _____