

## COVID-19 Positive Test Report Form

**Purpose:** Providers should use this form to report information on individuals enrolled in CHOICES or ECF CHOICES who have a *confirmed* positive test for COVID-19 (Novel Coronavirus) to the Managed Care Organization (MCO) through which the individual is enrolled.

This form should be emailed within **24 hours** from the discovery of the positive COVID-19 test to the MCO using the contact list below and subject heading **COVID Report MM/DD/YY**:

- Amerigroup: [TNCovid19notification@amerigroup.com](mailto:TNCovid19notification@amerigroup.com)
- BlueCare: [COVID19REPORTING LTSS@bcbst.com](mailto:COVID19REPORTING_LTSS@bcbst.com)
- UnitedHealthCare: [LTSSCMA@UHC.com](mailto:LTSSCMA@UHC.com)

<b>Current Date</b>	
<b>Provider Agency Name</b>	
<b>Services Provided</b>	
<b>Reported by</b>	
<b>Agency contact</b>	
<b>Member First Name</b>	
<b>Member Last Name</b>	
<b>Member ID</b>	
<b>Member Age</b>	
<b>Program</b> (CHOICES or ECF CHOICES)	
<b>Group</b> (2-8)	
<b>Region</b> (East, Middle, or West)	
<b>Date Tested Positive for COVID-19</b>	
<b>Setting Type</b> (this should be where the member was residing when tested positive)	
<b>Address of where member was residing when tested positive</b>	
<b>Did member go to a different setting after testing positive?</b> (Yes/No)	
<b>If Yes, Setting Type</b>	
<b>If Yes, Current Address</b>	
<b>Safety precautions being taken</b>	
<b>Has the worker/staff who have been in contact with the individual been notified?</b> (Yes/No)	
<b>Type of service being provided</b> (CLS, CLS-FM, Home Health, PA, etc)	
<b>If CLS, CLS-FM, please list number of housemates</b>	
<b>For any housemates that have a different payor from the individual that tested positive, please list payor sources</b> (DIDD, Amerigroup, BlueCare, UnitedHealthCare)	
<b>Does provider have sufficient PPE to use in accordance with CDC guidance?</b> (Yes/No)	

Please confirm that notifications are complete to the following (Yes or No):	
<b>Local Health Department</b> (including that individual is in a shared living arrangement and that impacted staff may work in other locations)	
<b>TDH Emergency Response Team</b>	
<b>Primary care (or other treating) provider</b>	
<b>Family member(s) or representative, as applicable, of person who is confirmed COVID-19 positive and family member(s) or representative of other persons living in the home (applicable for residential services)</b>	
<b>Other persons living in the home</b>	
<b>Staff who may have had contact with the person during the 14 days prior to the onset of symptoms up to implementation of isolation</b>	
<b>Outcome/Update/Resolution/Additional Comments</b>	