

**Agenda ID: XXXXXXXX**

&lt;MEMBER LAST NAME, MEMBER FIRST NAME&gt;&lt;MEMBER ID&gt;

**Member Phone:** (XXX)-XXX-XXXX

**Member DOB:** <M/D/YYYY>

**TIN Name:** <TIN NAME><TIN>-<STATE>

**IPAA Name:** <IPAA>

**Provider Name and ID:** <NPI NAME><NPI>

**2026 MARKETPLACE Appointment Agenda**
**A Guide to the Patient's Visit**

**Disclaimer:** Paper submissions take longer to process. For available electronic submission methods, please use the QR code or URL below.

Insight Information				Select a response indicating the Status of each Insight			
Insight Type	Insight Description	Diagnosis/Supporting Information	Relevant DOS	Active & Documented	Resolved/Not Present	Addressed Previously	Patient Referred
Risk Adjustment	<Insight Description>	<Diagnosis/Other Info/Supporting Information>	<MM/DD/YYYY>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Complexity	<Insight Description>	<Diagnosis/Other Info/Supporting Information>	<MM/DD/YYYY>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality	<Insight Description>	<Diagnosis/Other Info/Supporting Information>	<MM/DD/YYYY>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical	<Insight Description>	<Diagnosis/Other Info/Supporting Information>	<MM/DD/YYYY>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drivers of Health	<Insight Description>	<Diagnosis/Other Info/Supporting Information>	<MM/DD/YYYY>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For questions on the Appointment Agenda form, please contact your provider representative.**
**Please complete form, sign, and send via fax to 844-608-0465 or via secure email to [agenda@centene.com](mailto:agenda@centene.com)**

Please ensure all current diagnoses and care gaps for 2026 are documented in the patient's chart and submitted on the claim. By submitting this form, you attest that the information is accurate, based on your assessment during the encounter, and properly documented in the medical record. **Please Note: The Appointment Agenda cannot be used as a medical record.**


**Provider signature:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Provider printed name:** \_\_\_\_\_

**Provider credentials:** MD DO PA NP (circle one)



**CoC+ Provider FAQ:** Use the QR Code or URL to access the CoC+ Provider Frequently Asked Questions.



[centene.com/content/dam/corporate/educational-resources/CoC-Program-FAQ.pdf](https://centene.com/content/dam/corporate/educational-resources/CoC-Program-FAQ.pdf)

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