Cigna Behavioral Health Care Service is available to assist in treatment planning and support for our customers at the number listed.

500 Great Circle Drive, Nashville, TN 37228
Tel 866.780.8546 Fax 866.949.4846

Health Care Provider Referral: Medicare Advantage Depression Disease Management Program

The Medicare Advantage Depression Disease Management Program is designed for patients with a depressive disorder. The program provides coaching and support by care management staff to help improve your patient's adherence to treatment for depression.

To refer a patient to the Medicare Advantage Depression Disease Management Program, simply complete the patient information below. If time permits, please provide additional information in the medical information section. Referrals can be submitted by mail or fax. Program staff are available by phone if you would like additional information about this program.

Date: ____________ **Patient and Referral Information**

The following patient has current symptoms of depression and should be evaluated for the Medicare Advantage Depression Disease Management Program.

First: ____________ **MI:** ______ **Last:** ____________

Cigna ID: ____________ **State:** ______

Date of Birth: ____________ **Gender:** ☐ Male ☐ Female

Referred by: ____________ **Phone:** ____________

Physician name: ____________ **Physician phone:** ____________

Is this patient aware that s/he is being referred to the Medicare Advantage Depression Disease Management Program?

☐ **Yes** ☐ **No** **Comments:** ____________

Patient Medical Information (optional)

Is the patient receiving counseling? ☐ **Yes** ☐ **No**

Date of diagnosis: ____________ **Diagnosis:** ____________ **Code:** ____________

Is the patient currently taking antidepressant medication? ☐ **Yes** ☐ **No**

If yes, did you give patient samples? ☐ **Yes** ☐ **No**

Psychotropic Medication: ____________ **Dosage:** ____________ **Date started:** ____________

Psychotropic Medication: ____________ **Dosage:** ____________ **Date started:** ____________

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Has the patient ever been hospitalized for depression? ☐ **Yes** ☐ **No** If "Yes," discharge Date: ____________

Does the patient have any co-morbid medical conditions (e.g., diabetes)? ☐ **Yes** ☐ **No**

If "Yes," please list: ____________

Does the patient have any co-occurring behavioral health conditions? ***Please check all that apply:***

☐ Alcohol abuse/dependence
☐ Anxiety disorder
☐ Depression
☐ Social phobia
☐ Panic disorder
☐ Bipolar disorder
☐ Schizophrenia
☐ Substance abuse/dependence
☐ Phobias
☐ Post-traumatic stress disorder
☐ Obsessive-compulsive disorder
☐ Other: ____________

Thank you for your referral to the Medicare Advantage Depression Disease Management Program!

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