

2208 Hwy 121 #210, Bedford, TX 76021 Tel: 877-725-2688 FAX: 855-803-3526
Email: TXSTARPLUSDM@healthspring.com

Health Care Provider Referral: Disease Management Program

The Disease Management Program is designed for patients with chronic conditions. The program provides coaching and support by case management staff to help improve your patient's adherence to treatment.

To refer a patient to the 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 fax or email. Program staff are available by phone if you would like additional information about the program.

Date: _____ Patient and Referral Information

The following patient has current symptoms and should be evaluated for the Disease Management Program.

First: _____ MI: _____ Last: _____

Cigna-HealthSpring 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 Disease Management Program?
__ Yes __ No Comments: _____

Patient Medical Information (optional)

Is this patient currently taking antidepressant medication? __ Yes __ No

Does this patient have any of the following chronic conditions? *Please check all that apply:*

<input type="checkbox"/> Asthma	<input type="checkbox"/> End of Life Care Needs
<input type="checkbox"/> COPD	<input type="checkbox"/> Obesity
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Uncontrolled Diabetes
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Chronic Kidney Disease or ERSD	<input type="checkbox"/> Other _____

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

<input type="checkbox"/> Alcohol abuse/dependence	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Substance abuse/dependence
<input type="checkbox"/> Depression	<input type="checkbox"/> Post-traumatic stress disorder
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Psychosis
<input type="checkbox"/> Phobias	<input type="checkbox"/> Obsessive-compulsive disorder

Thank you for your referral to the Disease Management Program!

MCDTX_16_42626 04082016