PrimeTMS

Medication Management Referral Form:

Patient Name: _____ DOB: __/__/__ Phone: _____

Email: _____ Address: _____

INSURANCE CARRIER

- ○ Aetna
- ○ BCBS of Kansas
- ○ CIGNA
- ○ Coventry
- ○ Federal BCBS (FEP)
- ○ HUMANA
- ○ Other:
- ○ Medicare Advantage (UHC/AARP)
- ○ Tricare West
- ○ UMR
- ○ UHC
- ○ UHC Student Resources

We are accepting Medication Management Referrals for all major private plans including Medicare Advantage Plans (UHC, HUMANA, Aetna, etc.).
We **do not** accept classic Medicare or Medicaid for Medication Management Referrals
We **do** accept classic Medicare for Deep TMS treatment.

Insurance Member ID: _____ Is the patient the subscriber? ○ YES ○ NO

If NO, please list the subscriber's name as it appears on the insurance card. _____

Subscriber's DOB: / / Subscriber's Address _____

Referring Provider Information

Provider's Name: _____ Phone: _____

Fax: _____ Address: _____

Signature: _____ Date: __/__/__

Chief psychiatric complaint (ex. depression):

_____

Medication History

You may fax your previous and current relevant medications, if preferred: 888-965-5147

Past psychiatric medications:

_____

_____

Current psychiatric medications (please include dosage):

_____

_____

_____