

## APPENDIX D CIGNA Practitioner Forms





**Practitioner Update Form**

To update your demographic information, please complete this form or visit our online form at [www.cignabehavioral.com](http://www.cignabehavioral.com).

**Please note: this form is for updating information only. Claims should not be mailed or faxed to Network Services.**

<b>Fax To:</b> Network Services 860.687.7257	<b>Mail To:</b> Network Services CIGNA Behavioral Health 11095 Viking Dr, Ste 350 Eden Prairie, MN 55344
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**Name:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Provider ID #** (if known) \_\_\_\_\_

**Mailing Address** (Only 1 mailing address – for administrative correspondence, including authorization letters)

Street Address/PO Box	Suite	City	State	Zip Code
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**I am currently seeing patients at the following location(s):** (cannot be a PO Box)

Street _____	Suite _____	Street _____	Suite _____
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City/State _____	Zip _____	City/State _____	Zip _____
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Telephone # _____	Telephone # _____
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**I'm no longer seeing patients at the following location(s):**

Street _____	Suite _____	Street _____	Suite _____
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Street _____	Suite _____	Street _____	Suite _____
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**I want claim payments to be sent to the following location(s):**

Street _____	Suite _____	Street _____	Suite _____
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City/State _____	Zip _____	City/State _____	Zip _____
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Telephone # _____	Telephone # _____
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Tax ID # _____	Tax ID # _____
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Tax ID Legal Name _____	Tax ID Legal Name _____
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**I no longer want claim payments to be sent to the following location(s):**

Street _____	Suite _____	Street _____	Suite _____
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Street _____	Suite _____	Street _____	Suite _____
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**I am no longer using the following tax ID numbers:**

\_\_\_\_\_

**\*\*Please Copy This Page If More Space Is Required\*\***



## SELF-PAY AGREEMENT

I, \_\_\_\_\_, have been notified by my provider/facility  
 Participant Name  
 \_\_\_\_\_ and/or a CIGNA representative  
 Practitioner Name  
 \_\_\_\_\_ that my treatment is not a covered benefit under  
 CIGNA Representative Name  
 my benefit plan or that my treatment starting at \_\_\_\_\_ is no longer covered by  
 Date  
 my benefit plan because CIGNA had determined the treatment does not meet CIGNA's standards  
 for medical necessity. I am aware of CIGNA's formal clinical appeal process and have elected  
 not to appeal this decision. Instead, I have chosen to continue treatment with my  
 provider/facility on a self-pay basis starting \_\_\_\_\_, which is no earlier than signature  
 date. Date

I understand that it is my responsibility to pay \_\_\_\_\_ for  
 Amount  
 \_\_\_\_\_ and will not be reimbursed by CIGNA unless I am successful  
 Services  
 on a later appeal.

This Self-Pay Agreement applies only to the service listed above. If I move to another level of  
 care, an authorization from CIGNA must be obtained or another Self-Pay Agreement signed.

\_\_\_\_\_  
 Participant Signature Date

\_\_\_\_\_  
 Witness Signature Date



## INFORMED CONSENT FOR TREATMENT

**CIGNA cannot give you legal advice on informed consent. The following is a sample for illustration purposes. Please consult your lawyer for advice on an appropriate informed consent form for your practice.**

### INFORMED CONSENT FOR TREATMENT

I hereby request that \_\_\_\_\_ born \_\_\_\_\_ and residing at \_\_\_\_\_  
Participant Name Date of Birth

\_\_\_\_\_  
Street Address City State Zip Code Telephone Number  
be accepted for psychiatric, mental health, or alcohol and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from \_\_\_\_\_.  
Provider
2. I have been given information regarding my rights and responsibilities as a participant.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services from \_\_\_\_\_.  
Provider I understand that I am responsible to pay a copay and that it is payable each time I come for treatment.
5. I understand that I may address any concerns or grievances with my therapist or any other representative of CIGNA at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

\_\_\_\_\_  
Signature of Participant or Legal Consenter

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



**MINOR (Emancipated Minors Only):**

Due to the following reason \_\_\_\_\_,  
Reason

I have the legal capacity under applicable \_\_\_\_\_ law to apply for consent to  
State  
such treatment and services mentioned in this form, without parental consent.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**PARENT OR GUARDIAN:**

I, \_\_\_\_\_, do hereby state that I am the natural parent  
Parent or Legal Guardian  
or legal guardian of the participant; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



## Behavioral Treatment Record Review Tool

### Administrative

1. The Record is legible.
2. Presenting problems and relevant psychological and social conditions affecting the patient's medical and psychiatric status are documented.
3. Documentation of existence or absence of special status situations such as imminent risk of harm, suicidal ideation, or development potential are prominently noted, documented, and revised.
4. A psychiatric history is documented (a psychiatric history might include previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data, relevant family information, results of laboratory tests, and consultation reports.)
5. A mental status evaluation is documented (patient's affect, speech, mood, thought process, thought content, judgment, insight, attention/concentration, memory and impulse control)
6. Medical History: One of the following is documented: 1) There is no history of a medical condition relevant to the presenting problem, or 2) There is a history of some medical condition relevant to the presenting problem, in which case there is documentation of the condition, treatment, and medications.
7. Clients 12 & older: documentation includes last use, amount used, patterns of use, and treatment history or substances (includes cigarettes, alcohol, illicit or prescribed and over-the-counter drugs.)
8. A DSM-IV diagnosis is documented, consistent with the presenting problems, history, mental status examination, and/or other assessment data.

### Treatment Planning

9. Initial treatment plan includes measurable goals, including documentation of any changes to treatment plan.
10. Patients who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.
11. The record documents preventive services as appropriate, such as relapse prevention, stress management, wellness programs, lifestyle changes and referrals to community resources. (includes advice/info on diet, exercise, smoking cessation, etc.)
12. Progress note is documented on each visit.

### Coordination of Care

13. The record reflects attempts to coordinate behavioral care with the primary care physician at ANY time during treatment when coordination of care is indicated.
14. The record reflects attempts to coordinate behavioral care with other behavioral clinicians or institutions or ancillary providers as indicated at any time during treatment.

### Child/Adolescent

15. For children and adolescents, prenatal and perinatal events, and a complete developmental history (physical, psychological, social, intellectual, academic, and substance abuse) are documented.

### Medications/Allergies (Applicable only to physicians and nurse practitioners who can prescribe medications)

16. The record documents whether or not the patient has any allergies or adverse reactions to medications.
17. All medications prescribed by THIS provider are listed along with the dosage of each.

### Medicare (Applicable only to Medicare cases)



18. Documentation of whether or not an advance directive was executed.

19. Evidence that a copy of executed advanced directive, or documentation of refusal, was sent to the PCP.

**Non-scored question:**

The record contains validated and standardized diagnostic/severity rating scales for the following conditions

- Depression
- Alcohol and other substance abuse



Form **W-9**  
(Rev. November 2005)  
Department of the Treasury  
Internal Revenue Service

### Request for Taxpayer Identification Number and Certification

Give form to the  
requester. Do not  
send to the IRS.

Print or type  
See specific instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ .....	
<input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

#### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number								

or

Employer identification number								

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

#### Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

**Certification Instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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#### Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,