



Depression Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
Attn: Underwriting Department
P. O. Box 13047
Roanoke, VA 24030
Customer Svc. Phone: 1-800-718-8831
Fax: 1-800-327-9255

Date: _____

Return by: _____

Underwriting Specialist: _____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information regarding the health status of _____. (You may use additional paper if necessary. All additional sheets must be signed and dated by the primary applicant). PLEASE INITIAL & DATE ANY ALTERATIONS.

1. Name, address and specialty of provider(s)/physician(s) who is treating or has treated the following mental/psychiatric condition:

Name _____ Address _____

Indicate provider's specialty (check one): General Practice Psychologist Psychiatrist
 Licensed Clinical Social Worker (LCSW) Medical Internist
 Licensed Professional Counselor (LPC) Other _____

Name _____ Address _____

Indicate provider's specialty (check one): General Practice Psychologist Psychiatrist
 Licensed Clinical Social Worker (LCSW) Medical Internist
 Licensed Professional Counselor (LPC) Other _____

2. What was the reason for first seeking treatment? _____ Date of first treatment: _____

3. What did your physician call the condition (diagnosis)? _____

(continued on next page)

4. Describe reason for Office Visit and include **ALL** dates of service:

Date of Visit (mm/dd/yyyy)	Provider's Name	Treatment Received (please check all that apply):
		<input type="checkbox"/> Medication Refill <input type="checkbox"/> Counseling <input type="checkbox"/> Medication Adjustment <input type="checkbox"/> Other (please explain) _____ _____
		<input type="checkbox"/> Medication Refill <input type="checkbox"/> Counseling <input type="checkbox"/> Medication Adjustment <input type="checkbox"/> Other (please explain) _____ _____
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5. Date of last treatment: _____ Date of last provider visit for this condition: _____
 Are there any on-going symptoms or treatment related to the above condition(s)? Yes No
 Explain: _____

6. Was medication prescribed or used for this condition? Yes No **If yes, please complete the chart below:**

Name of Medication(s)	Dosage and/or Frequency	Date Started (mm/dd/yyyy)	Date Stopped (mm/dd/yyyy) (If still taking, indicate "current")

7. Has this person been advised to seek treatment from another provider for this condition? Yes No **If yes, please indicate the name and address of that physician, and the reason for the referral.** _____

8. Has this person required hospitalization for the condition listed above? Yes No **If yes, please indicate when and which hospital.** _____

9. Has this person ever attempted suicide? Yes No **If yes, please explain and include dates:** _____

10. Has this person been advised of the need for future treatment related to this condition(s), including follow-up visits to the treating provider or physician? Yes No **If yes, please explain:** _____

(continued on next page)

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

Signature of Applicant or Legal Representative

Date ____/____/____
mo. / day / year

Signature of Spouse or Other Adult to be covered
(if applying for coverage)

Date ____/____/____
mo. / day / year