



5502 58TH STREET, SUITE 700
LUBBOCK, TEXAS 79414
(806) 794-0844
(806) 783-0895 – FAX

Group Name: _____

Group Number: _____

Employee Name: _____

Policy I.D. Number: _____

Patient: _____

PATIENT PRE-EXISTING QUESTIONNAIRE

We have received medical claims for you and find additional information is needed before processing. Please answer the questions below, sign and date and return to us.

1. Have you received any treatment within the 6 months prior to your effective date?
Yes_____ No_____

2. If yes, list dates of treatment:_____

3. What date did the symptoms begin?_____

4. Were any drugs prescribed for this illness within the 6 months prior to your effective date?

Yes_____ No_____

5. If yes, list name of each drug and date purchased_____

6. List names and addresses of all physicians who you saw for **any condition** within the 6 months prior to your effective date. **Include the reason you were seen or treated.**

7. List names and address of all pharmacies used within the 6 months prior to you effective date.

This is to certify that no expense, treatment, consultation (in person or by phone), or prescriptions for any reason have been incurred for _____ except as listed above.

Signature of Employee

Date