



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: _____

PROVIDER PRE-EXISTING QUESITONNAIRE

We have received several medical claims for your patient in connection with the above. Upon review of this claim, we find that we need additional information.

1. Patient seen or treated within the 6 months prior to the effective date?

Yes_____ No_____

2. If so, for what condition?_____

3. Dates symptoms first appeared? _____

4. Date first consulted by patient?_____

5. Dates of all subsequent treatment. If more frequent than once a month, merely indicate inclusive dates._____

6. Date patient first advised of this condition by you?_____

7. Medication prescribed?_____

8. Name and address of referring physician or any other physicians consulted by your patient for this condition?_____

Signature

Date

Your cooperation is greatly appreciated.