DELTA HEALTH SYSTEMS
ADMINISTRATION SERVICES

Pre-Existing Condition Questionnaire

Claim# Insert claim number

Health Care ID# Insert participant health care ID

Insert Provider or Office name

Plan Participant: Insert plan participant name

Insert Address

Patient: Insert patient's name

Insert City, State Zip

Acct:

Dear Doctor,

In order to process a recently received claim, we will need the following additional information (*note: please use the reverse side of this questionnaire if more space is needed to answer the questions below*):

1. Did you treat this patient from Insert date to Insert date ? Yes ○ No ○
   If yes, please list the dates of visits and the diagnosis (ICD-9 code) for each visit.

2. Was the patient taking prescribed medication for ANY conditions during the dates shown in question #1? Yes ○ No ○
   If yes, please indicate the specific drug(s) being taken, date(s) first prescribed, and frequency of use.

3. Was the patient hospitalized for ANY condition during the dates shown in Question #1? Yes ○ No ○
   If yes, give the date(s) and name and address of attending physician.

4. Was the patient treated for ANY condition by any other physician between the dates shown in Question #1? Yes ○ No ○
   If yes, give the date(s) and name and address of the other physician.

_____ _____

Doctor's Signature Date

We will complete our review of your claim upon receiving this completed form. Thank you for your assistance.

Sincerely,
Claims Department