DELTA HEALTH SYSTEMS
ADMINISTRATION SERVICES

Pre-Existing Condition Questionnaire

06/05/2014

Claim #: Insert claim number
Health Care ID: Insert Healthcare ID
Patient: Insert Patient Name
Relationship: Insert Your Relation To Member
Effective Date: Insert Effective Date

Insert Name
Insert Address
Insert City State Zip

Your health plan limits coverage for conditions that existed in the insert months **months prior to your effective date. Please reply to our office within the next 15 days to avoid delays in claim processing.**

Do you have a Certificate of Creditable Coverage from your prior carrier: Yes ☐ No ☐
If yes, please forward the Certificate to Delta Health Systems within 15 days; you do not need to complete this form. Credit to reduce the pre-existing limitation period may be allowable if the participant was covered under another individual, group or public assistance plan. The participant must be covered under this plan within sixty three (63) days of loss of coverage on the prior plan. To establish this credit, a letter from the prior carrier or prior employer showing the effective and termination dates must be sent to our office.

If you can not provide a Certificate of Creditable Coverage, please provide the following information for treatment during this time period (*note: please use the reverse side of this questionnaire if more space is needed to answer the questions below*):

1. Has this patient been treated by a physician? Yes ☐ No ☐
   If yes, please list dates of visits, the diagnosis for each visit, and the physician's name and address.

2. Has the patient been prescribed any prescription drugs? Yes ☐ No ☐
   If yes, please list the name of the drug(s), frequency of use, the date first prescribed, and the prescribing physician's name and address.

3. Has the patient been hospitalized? Yes ☐ No ☐
   If yes, please list the dates, the name of the hospital and the attending physician.

I certify that the above information is correct.

_____ _____
Participant's Signature Date

If you have any questions please contact our Eligibility Department – they will be happy to assist you in any way possible.

Sincerely,
Claims Department

Phone: (800) 422-6099 * Fax: (209) 474-5407 * P.O. Box 80 Stockton, CA 95201-3080