



# MEDICAL TREATMENT HISTORY REQUEST

If prior health insurance coverage exists, please submit a copy of the Certificate of Creditable Coverage to BCBSM along with this form.

PART 1 - TO BE COMPLETED BY PATIENT		
Patient Name	Subscriber Name	Contract Number
Patient Date of Birth	Group Number	Employer

Check either "yes" or "no" to indicate if the patient has been treated by a physician for any of the following conditions six months prior to the enrollment date. If yes, have each treating physician complete part 2. If you are unsure of the enrollment date please contact your employer's benefit representative for the information.

CONDITION	YES	NO	CONDITION	YES	NO
<b>Endocrine Disease/Condition</b> ■ Diabetes or Hypoglycemia ■ Thyroid Disease ■ Glandular Problems			<b>Gastrointestinal Disease/Condition</b> ■ Bowel or Rectal disorders ■ Liver disease ■ Stomach Conditions		
<b>Cardiovascular or Circulation Disease/Condition</b> ■ Blood Pressure      ■ Heart Disease ■ Stroke                ■ Phlebitis			<b>Central Nervous System Disorders</b> ■ Epilepsy or Seizures ■ Migraine or Severe Recurrent Headaches		
<b>Musculoskeletal Disease/Condition</b> ■ Joint or Bone Injury ■ Foot Problems			<b>Renal Disease/Condition</b> ■ Kidney Problems      ■ Bladder Problems ■ Urinary Problems		
<b>Respiratory Disease/Condition</b> ■ Tuberculosis      ■ COPD ■ Asthma			<b>Ear or Eye Condition</b>		
			<b>Cancer/Tumors</b>		
			<b>Alcoholism or Drug Abuse</b>		
<b>Skin Conditions</b>			<b>Mental or Nervous Disease/Disorder</b>		
<b>Reproductive Organ Disease/Condition</b> ■ Pelvic Disease			<b>Other Disease/Injuries/Conditions</b>		

If any of the above boxes are checked "yes", please explain each "yes" below.

CONDITION	DATE	TREATING PHYSICIAN NAME/ADDRESS/PHONE NUMBER

Prior to your enrollment date, has the patient taken any prescription drugs that were ordered by a doctor? If "yes", please attach a copy of the pharmacy printout of medications prescribed and refilled.

I certify that the information I have given is complete and true to the best of my knowledge and belief. I authorize Blue Cross Blue Shield of Michigan to obtain any and all records from providers of services, including but not limited to, records regarding conditions, treatments, surgeries, tests, prescriptions and other information that BCBSM deems necessary. This information will be used for claims administration. I understand I will be responsible for any amount that may be charged by my physician.

Signature of Patient (parent or guardian if a minor)

(Area Code) Phone Number

Date

**Return to: Attn: Pre-Existing Review - Mail Code B437  
 Blue Cross Blue Shield of Michigan  
 600 E. Lafayette Blvd.  
 Detroit, MI 48226-2998**

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

**PART 2 - TO BE COMPLETED BY PHYSICIAN**

Patient Name \_\_\_\_\_ Contract Number \_\_\_\_\_

If you did not treat or prescribe medications for the above patient six months prior to the enrollment date, please check here  and sign below.

When did you first treat the patient? \_\_\_\_\_ Diagnosis/ICD-9 \_\_\_\_\_

**Please complete the following for each service/prescription that you have provided the patient during the six months prior to the enrollment date.**

DATE	TYPE OF SERVICE & PRESCRIPTION	DIAGNOSIS & ICD-9	IS PATIENT STILL UNDER TREATMENT?	
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>
			YES <input type="checkbox"/>	NO <input type="checkbox"/>

If you are aware of any other provider(s) who provided services or prescribed drugs for the patient during the six months prior to the enrollment date, please provide the following information.

PROVIDER NAME/PHONE NUMBER	ADDRESS	CITY	STATE	ZIP CODE

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please type/ Print your name

\_\_\_\_\_  
(Area Code) Phone Number

ADDRESS	CITY	STATE	ZIP CODE

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# PRE-EXISTING GENERAL INFORMATION REQUEST

We are using this form to request additional information. We must receive this completed form no later than 45 days from the date of this request, or claims for this patient will not be processed.

DATE	PATIENT NAME	
PATIENT DATE OF BIRTH	PROVIDER NAME	
CONTRACT/GROUP NUMBER		DATE OF SERVICE

**NOTE: Subscriber's application card states: "It is understood that Blue Cross Blue Shield of Michigan may examine any record of hospitalization or medical treatment for family members and myself and that hospitals, doctors, and other providers of service may furnish such records and reports to Blue Cross Blue Shield of Michigan."**

The following records are necessary to ensure proper adjudication of the claim:

The period of time the records must cover \_\_\_\_\_ to \_\_\_\_\_.

- 1. Medical history and physical
- 2. Discharge summary
- 3. Physician orders
- 4. Progress notes
- 5. Nursing care notes/assessment
- 6. Medication records/graphic flow sheets
- 7. Operative report
- 8. Lab reports/ekg/pathology reports
- 9. Consultation reports
- 10. Office notes
- 11. Other \_\_\_\_\_

Please send the complete medical records for benefit determination to:

Attn: Pre-Existing Review - Mail Code B437  
 Blue Cross Blue Shield of Michigan  
 600 E. Lafayette  
 Detroit, MI 48226-2998

TO BE COMPLETED AND RETURNED BY THE PROVIDER	
SIGNATURE	
PRINT NAME AND TITLE	

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