PLANNED ADMINISTRATORS INC

PRE-EXISTING INFORMATION FORM

Reason for this form: This form is to be used so that claims will be processed correctly according to conditions that may have existed prior to coverage with your group health plan.

EMPLOYEE NAME: _____

PATIENT NAME: _____

SOCIAL SECURITY NUMBER OF INSURED: _____

GROUP NAME: _____

RE: Information needed to process your claim(s).

We recently received a claim for processing on the above referenced patient. In order to possibly reduce or eliminate your pre-existing condition waiting period, we will need the following information. If this information is not received back, we may not be able to determine your proper benefits and thus not process your claims(s).

PLEASE PROVIDE INFORMATION FROM DATES OF SERVICE BETWEEN:

_____

If the above referenced patient had prior medical coverage without a break in coverage of more that 63 days, you may submit a certificate of prior coverage. This letter of prior coverage can be obtained from your previous insurer.

Prior Coverage letter from your prior insurer is attached (circle one): YES NO

If the answer to the above question is NO, please complete the following:

- During the time period listed above I (**have / have not**) seen any doctor(s).
- If you **have** – Please list the doctor(s) and the address where you were seen on the following lines:

  _____

  _____

  _____

  _____

Please return the completed letter to: Planned Administrators, Inc.
PO Box 6927
Columbia, SC 29260

Thank you for your cooperation.

PAI Claims Representative