



## PROVIDER PRE-EXISTING INFORMATION

**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 the claimant's group health plan.

Employee Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Social Security Number of Insured: \_\_\_\_\_

Group Name: \_\_\_\_\_

Provider Name: \_\_\_\_\_

We have received a claim for your patient. To promptly and properly process the claim, we need the following information from you.

FOR DATES OF SERVICE: \_\_\_\_\_

Please list all dates you have seen or treated the patient and the condition you diagnosed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To your knowledge, if another physician saw or referred the patient, please list the physician's name and address:

\_\_\_\_\_  
\_\_\_\_\_

To your knowledge, have any medications been prescribed for this patient?    Yes \_\_\_\_\_    No \_\_\_\_\_

If yes, please give names of drugs and purchase dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Please attach the patient records to this letter and return it to:

*Planned Administrators, Inc.  
PO Box 6927  
Columbia, SC 29260*

Thank you for your cooperation.

Sincerely,

*PAI Claims Representative*