HealthComp

Date _____/_____/_____

Patient: _____ Group No: _____
Employee: _____ Acct No: _____
Claim No: _____ Incurred: _____
Provider: _____ Charge: _____

Request for Information

Do you have a Certificate of Creditable Coverage from your prior plan?

Please check one

_____ **Certificate of Creditable Coverage is attached** (If your prior coverage lasted less than 12 months before joining your current Plan, or if that coverage terminated more than 63 days before you joined your current Plan, please complete the Request for Provider History portion of this form. Otherwise, please sign and date this form where indicated below and return it to HealthComp).

_____ **No prior coverage** (If you did not have coverage prior to joining your current Plan, please complete the Request for Provider History portion of this form, and then sign and date where indicated below and return it to HealthComp).

Request for Provider History

Please provide the name and address of any health care providers that have treated the patient at any time during the period of _____ through _____.

NAME OF PROVIDER*	COMPLETE ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

* Please include pharmacies. Use additional pages if necessary to list all providers

If the patient did not receive treatment within the dates specified above, please indicate below.

I was not treated within the dates specified _____ (check here if applicable)
I verify that this information is true and accurate to the best of my knowledge.

Please sign here _____ Date