HSR
Health Special Risk, Inc.

Prior Treatment Questionnaire

Do not leave any questions blank. Please provide as much detail as possible

A. PATIENT INFORMATION

Name (Last, First, MI)	Date of Birth(MM/DD/YY)

Student ID Number: 999-	School Name:
First Date of sickness:	Date physician was seen for this sickness:

Symptoms of sickness for which you were seen or treated : *(Use back if more space is needed)*

Were you ever seen or treated for this sickness in another country other than the United States? ☐ YES ☐ NO
If YES, please indicate where and when:

B. PHYSICIAN(s) INFORMATION

Please list name(s) and phone number(s) for ALL physicians seen for the above sickness. *(Use back if more space is needed)*

Physician Name	Physician Phone Number	History of Treatment (ALL Medication and Surgical Procedures)

C. OTHER COVERAGE

Do you have other insurance that covers your condition? (Group, Individual or Medical)
☐ YES ☐ NO **If YES, please provide a copy of Insurance card.**

If you were covered for health benefits under another group health plan within the 62 day period immediately preceding your effective date under this group policy, you may be eligible to have pre-existing condition limits or waiting periods either reduced or waived as described in your policy booklet. In order to maximize your benefit coverage under this plan, please attach a copy of your "Prior Creditable Coverage Certificate" provided to you by your previous insurance plan administrator.

D. FRAUD WARNING

Any person, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, who submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Patient Signature _____ Date _____

Return to: Health Special Risk, Inc. ♦ 4100 Medical Parkway ♦ Carrollton, TX 75007 ♦ Phone: (866) 345-0974