HIGHMARK® Delaware

ATTENDING PHYSICIAN'S STATEMENT

Physician's Name **Number & Street** **City & State** **Zip Code**

Dear Doctor: Highmark Blue Cross Blue Shield Delaware (Highmark DE) needs certain medical history information from you to further consider my medically underwritten application for Highmark DE health care coverage. As Highmark DE does not provide reimbursements for charges related to providing the information requested below, please contact me directly for payment if you charge a fee for responding to this request.

I authorize you to furnish Highmark DE the information requested concerning the patient listed below. Please complete this form and use the enclosed envelope to mail it to Highmark DE **within 20 days** of your receipt of this request. Thank you for your help.

Date Patient's Signature

If patient is a spouse or child, please provide the name of the primary applicant: _____

TO BE COMPLETED BY PHYSICIAN

Patient Name: _____ **DOB:** _____

Please provide the following information:

Date of last visit:	**Date of last physical exam:**	**Height:**	**Weight:**
Blood Pressure:	**Cholesterol reading(s):**	**Tobacco Usage:** ☐ Yes ☐ No	**Alcohol intake per week:**

Has patient ever been treated for any of the following? Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling.	**Yes or No**	**If yes, please comment.**
1. Cancer or any pre-cancerous conditions	☐ Yes ☐ No	
2. Migraine headaches, TIAs, CVAs or seizures	☐ Yes ☐ No	
3. Heart disease (coronary, congenital, structural, arrhythmia, valvular) or Hypertension	☐ Yes ☐ No	
4. Asthma, COPD or other lung and respiratory diseases	☐ Yes ☐ No	
5 Back or other musculoskeletal conditions	☐ Yes ☐ No	
6. Liver/pancreas disease, or inflammatory or other bowel diseases	☐ Yes ☐ No	
7. Diabetes or other endocrine/metabolic disorders	☐ Yes ☐ No	A1C reading _____
8. Kidney/urinary tract disease or renal failure	☐ Yes ☐ No	Creatinine clearance _____
9. Chronic skin conditions or blood disorders	☐ Yes ☐ No	
10. Behavioral health conditions	☐ Yes ☐ No	
11. Alcohol/drug abuse or dependency	☐ Yes ☐ No	

Additional doctor's notes from above or comments on any other medical condition not listed above:

Please list current medications or treatments:

Any anticipated care, treatment or surgery in the next 12 months? ☐ **Yes (please explain)** ☐ **No**

Any surgeries in the last seven years? ☐ **Yes (please explain)** ☐ **No**

Please provide the names of other doctors (including oral surgeon and chiropractor) seen in the last seven years:

Physician's signature **Date** **Address**