

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:

**Essential StaffCARE
PO Box 6702
Columbia, SC 29260**

Thank you for your cooperation.

Sincerely,

Claims Representative

8906 Two Notch Road
Columbia, South Carolina 29223

Post Office Box 6702
Columbia, South Carolina 29260-6702

Phone (866) 798-0803
Fax (803) 264-0772