

To: _____

HCH ADMINISTRATION IS IN RECEIPT OF A CLAIM ON THE ABOVE-NAMED PATIENT. UNFORTUNATELY, WE ARE UNABLE TO PROCESS THIS CLAIM UNTIL WE RECEIVE THE INFORMATION REQUESTED BELOW. YOUR RESPONSE MUST BE IN WRITING.

RE: PRE-EXISTING INVESTIGATION

Please indicate the name, address, and phone number of the physician(s) seen and pharmacies used between: _____

I authorize any physician, medical practitioner, hospital, medical clinic, other provider of health care, any insurance company, or employer to disclose to HCHA or its authorized medical, underwriting and claims representatives all information and records relating to a diagnosis, treatment, medical history, physical and mental condition and evaluation, or any other information related to me or my dependents. This authorization remains valid for 30 months from this date.
Signature: _____ Date: _____

AS SOON AS WE RECEIVE THE REQUESTED INFORMATION, YOUR CLAIM WILL BE GIVEN IMMEDIATE ATTENTION. THE CLAIM MAY BE REOPENED UPON SUBMITTAL OF THE REQUESTED INFORMATION, PROVIDED IT IS SUBMITTED WITHIN THE FILING LIMITATIONS OF THE PLAN. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT AT (309) 673-7330 OR (800) 322-1516

Sincerely,

Claims Department