BlueCross BlueShield of Tennessee Inc., an Independent Licensee of the BlueCross BlueShield Association

Medical Questionnaire - Diagnosis Detail

Employee Name: _____ **Soc. Sec. No.:** _____

Instructions: Answer ALL of the questions on the first page. Also answer the applicable questions on the second page if you answered "yes" to questions 1, 4, 5 or 13 on Part A of the Small Group Health Questionnaire (or if disclosing medical conditions related to Cancer, Reproductive System, Diabetes or Transplant and were not required to populate a Small Group Health Questionnaire) concerning the medical conditions of the following person:

_____**(name of the person with condition).**
This form may be completed by the employee, a legal guardian, a spouse or agent. State "none" if question is not applicable. Provide only personal medical information for the person with condition. Do not include genetic testing/ genetic screening results or family medical history. Extra sheets may be used if additional space is needed; but please include your name and question number with each response. A request for medical records may be required for complete evaluation.

1. What is the condition and what date was it diagnosed (if Hepatitis, please indicate which type)? _____
   _____
   _____

2. How is/was this condition treated? (Include dates, frequency of visits to medical provider, all hospitalizations, therapy, and prior or planned surgeries): _____
   _____

3. What prescription drugs are currently being taken or have been taken in the past for this condition? (Include dates and the amount of the medication taken):
   _____
   _____
   _____

4. What is the prognosis of the illness, including the likelihood of any future treatments or surgeries? Have there been any recommendations for treatments? _____
   _____
   _____
   _____

If you answered yes to question 1, 4, 5 or 13 in Part A of the *Small Group Health Questionnaire* (or if disclosing medical conditions related to Cancer, Reproductive System, Diabetes or Transplant and were not required to populate a *Small Group Health Questionnaire*), please answer the applicable question(s) below:

(A1) Answer the following if **Breast Cancer or Melanoma has existed within the past 10 years OR any other Cancer within the past 5 years – including Leukemia, Lymphoma, Hodgkin's, or Malignant Cysts:**

Type of Cancer	Date Diagnosed	Parts of body affected	Lymph Node Involvement?	Chemotherapy or Radiation Start Date	Completed
_____	___/___/____	_____	☐Yes ☐No	_____	_____
_____	___/___/____	_____	☐Yes ☐No	_____	_____
_____	___/___/____	_____	☐Yes ☐No	_____	_____

Provide details as to the current status, any recurrence of the condition and future treatment recommended:

_____

_____

(A4) Answer the following for **Premature Infants (born at 37 gestational weeks or less) currently less than 24 months of age:** Number of gestational weeks when born _____ Date of birth _____

List any birth complications and/or medical problems associated with the premature birth, including RSV treatment such as Synergis injections (give dates)_____

_____

If **Cervical Dysplasia**: the type cell found _____, the grade of Squamous cell _____, and dates of last ***normal*** pap smears (1)_____(2)_____

(**A5) Diabetes:**

	Date	Results	Check if Unknown
a. Most recent Glycohemoglobin A1C	_____	_____	☐

b. Last 3 Blood Sugar Readings: Taken in Doctor's Office		Date	Blood Sugar Reading	Check if Unknown
☐Yes	☐No	1._____	_____	☐
☐Yes	☐No	2._____	_____	☐
☐Yes	☐No	3._____	_____	☐

Has there been an eye disorder diagnosis? If yes, please explain, including diagnosis, date of diagnosis, and treatment:

_____

_____

Do any of the following exist: High Blood Pressure (if yes, provide last blood pressure reading), Kidney disease, heart condition, numbness/pain to hands or feet (neuropathy)? If yes, please explain, including current medications/treatment:

_____

_____

(A13) Answer the following if an **Organ or Bone Marrow Transplant** has either occurred or is being awaited:

a. Primary Diagnosis (reason for and type of transplant) _____

_____

b. How is/was the condition treated (surgery, hospitalizations, etc.)? _____

_____

c. Has there ever been a rejection, limitations, or current symptoms due to a previous transplant? If yes, explain.

_____

_____

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Completed by (Print Name):_____Relationship to person with condition:_____

Signature: _____ Date: _____