



# MVP Health Plan Inc. Medical Questionnaire

**This form must be completed and returned via fax or mail within 30 days of receipt.**

|   |      |           |                    |               |
|---|------|-----------|--------------------|---------------|
| First Name                              | M.I. | Last Name | Member I.D. Number | Date of Birth |
| Street Address                          |      | City      | State              | Zip Code      |
| Primary Care Physician Name and Address |      |           |                    |               |

1. Have you had health insurance coverage during the 12 months prior to enrollment with MVP Health Plan Inc?  
 If yes, check the box and please **submit the HIPAA certificate when submitting the questionnaire.**  Yes  No
- In the past six months, has the person indicated above been treated by or consulted a physician/practitioner?  Yes  No

2. Please check if you have been treated for the following conditions during the six months prior to your enrollment.  
 If you had a diagnosis or treatment for a condition not noted in the table, please describe under "Other conditions not noted in table."

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Crohn's disease  | <input type="checkbox"/> Hemorrhoids   | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Croup  | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Thyroid disease   |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Cystic fibrosis  | <input type="checkbox"/> Hernia  | <input type="checkbox"/> TMJ   |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Deafness/hearing aid   | <input type="checkbox"/> High blood pressure/<br>hypertension  | <input type="checkbox"/> Tonsillitis   |
| <input type="checkbox"/> Arthritis<br>( <i>rheumatoid or osteoarthritis</i> )                   | <input type="checkbox"/> Depression   | <input type="checkbox"/> High cholesterol/<br>hyperlipidemia   | <input type="checkbox"/> Ulcer<br>( <i>explain: _____</i> )                            |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Developmental problems   | <input type="checkbox"/> High lead level   | <input type="checkbox"/> Ulcerative colitis  |
| <input type="checkbox"/> Attention deficit disorder<br>( <i>with or without hyperactivity</i> ) | <input type="checkbox"/> Diabetes   | <input type="checkbox"/> HIV/AIDS  | <input type="checkbox"/> Varicose veins  |
| <input type="checkbox"/> ADD/ADHD   | <input type="checkbox"/> Diverticulosis   | <input type="checkbox"/> Infertility   | <b>OTHER DISORDERS</b>   |
| <input type="checkbox"/> Back pain  | <input type="checkbox"/> Drug abuse   | <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Breast disorders  |
| <input type="checkbox"/> Behavioral problems  | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Kidney failure<br>( <i>require dialysis? <input type="checkbox"/> yes <input type="checkbox"/> no</i> ) | <input type="checkbox"/> Eyes, ears, nose, throat disorder                             |
| <input type="checkbox"/> Bladder infections   | <input type="checkbox"/> Enlarged heart   | <input type="checkbox"/> Kidney stone  | <input type="checkbox"/> Female reproductive<br>system disorder                        |
| <input type="checkbox"/> Bladder or kidney infection  | <input type="checkbox"/> Epilepsy or seizures   | <input type="checkbox"/> Lupus   | <input type="checkbox"/> Heart or circulation disorder                                 |
| <input type="checkbox"/> Bleeding disorder  | <input type="checkbox"/> Exposure to TB or active TB  | <input type="checkbox"/> Meningitis  | <input type="checkbox"/> Liver, stomach, spleen<br>or pancreas disorder                |
| <input type="checkbox"/> Blindness  | <input type="checkbox"/> Frequent ear infections  | <input type="checkbox"/> Menstrual problems  | <input type="checkbox"/> Lung or breathing disorder                                    |
| <input type="checkbox"/> Blood transfusion  | <input type="checkbox"/> Gall bladder disease   | <input type="checkbox"/> Migraine headaches  | <input type="checkbox"/> Male reproductive<br>system disorder                          |
| <input type="checkbox"/> Breast lump  | <input type="checkbox"/> GERD   | <input type="checkbox"/> Mitral valve prolapse   | <input type="checkbox"/> Muscle disorder   |
| <input type="checkbox"/> Broken bones   | <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> Muscular dystrophy  | <input type="checkbox"/> Neurological disorder   |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Gonorrhea, chlamydia,<br>syphilis, genital herpes,<br>human papilloma virus,<br>or other sexually transmitted<br>disease ( <i>circle</i> ) | <input type="checkbox"/> Obesity   | <input type="checkbox"/> Psychiatric disorder  |
| <input type="checkbox"/> Cancer<br>( <i>explain: _____</i> )                                    | <input type="checkbox"/> Gout   | <input type="checkbox"/> Paralysis   | <input type="checkbox"/> Skeletal ( <i>bone</i> ) disorder                             |
| <input type="checkbox"/> Cataracts  | <input type="checkbox"/> Growth hormone problem   | <input type="checkbox"/> Peripheral vascular disease   | <input type="checkbox"/> Skin disorder ( <i>acne, eczema,<br/>rosacea, psoriasis</i> ) |
| <input type="checkbox"/> Cerebral palsy   | <input type="checkbox"/> Head/brain injury  | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Urinary disorder<br>( <i>bladder, kidney</i> )                |
| <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Hearing problems   | <input type="checkbox"/> Prostate problem<br>( <i>explain: _____</i> )   |  |
| <input type="checkbox"/> Colitis  | <input type="checkbox"/> Heart attack   | <input type="checkbox"/> Pulmonary hypertension  |  |
| <input type="checkbox"/> Congenital anomalies<br>( <i>birth defects</i> )                       | <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> Rheumatic fever   |  |
| <input type="checkbox"/> Congestive heart failure   | <input type="checkbox"/> Hemophilia   | <input type="checkbox"/> Sick cell anemia  |  |
| <input type="checkbox"/> Convulsions  |   | <input type="checkbox"/> Sleep apnea   |  |

**Other conditions not noted in table:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



3. Have you been diagnosed, treated, or advised to seek treatment by a health care professional within the last six months for (check appropriate box):

- a.  Recurrent infections                       Enlarged lymph glands                       Unexplained weight loss  
 Skin rash     Oral lesions     None of the above

b. A condition for which surgery was performed within the past six months, or for which surgery has been recommended?  Yes    No

c. Any other condition for which the person has been under a doctor's care, or been confined to a hospital or other medical facility with the last six months?  Yes    No

4. Is the person listed on this form currently pregnant? (*Individual contracts only*)  Yes    No

5. Have you been taking medications prescribed by a practitioner within the last six months prior to enrollment with MVP Health Care? If yes, explain in Detail in question #7. Include the name of the medication being taken, what condition it is being taken for, and the practitioner who prescribed it.  Yes    No

6. Explain in full detail all "YES" answers to questions 1-6. If you suffer a condition identified above, please include treatment, name of medication, and the effectiveness of treatment. If more space is needed, use a separate piece of paper, and include your name and ID number.

| Question Number | Name of Condition | Dates of Treatment or Medications | Type of treatment, duration and effectiveness of treatment and description of medications | Attending Physician/Hospital and Address |
|-----------------|-------------------|-----------------------------------|---|--|
|                 |                   |                                   |   |  |
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Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Member Name \_\_\_\_\_ Member Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Please print)* *(Under age 18, parent or legal guardian signature)*

Please return this questionnaire in the enclosed self-addressed stamped envelope or fax to **518-386-7417**.

