Universal/Uniform Medical Assessment Form (Group size 2+)

Employer Group Name: _____

This information is used to evaluate the medical risk of a group and may be provided to the following carriers to be used in accordance with each Health Plan's Underwriting Guidelines:

BCBSNM[1]
5701 Balloon Fiesta Parkway NE
Albuquerque, NM 87113
Attention: Sales – HQ – 4th Floor

Lovelace Health Plan[2]
4101 Indian School Road NE
Albuquerque, NM 87110
Attention: Underwriting Department
E-mail: lhs.underwriting@lovelace.com
E-fax: 505.727.9522

Presbyterian[3]
Contact your insurance agent or broker, or contact our new sales team at 505.923.5807, or e-mail us at presalesrfp@phs.org.

United Healthcare[4]
8220 San Pedro NE
Albuquerque, NM 87113

[1] Blue Cross and Blue Shield of New Mexico is a Division of Health Care Service Corporation, a Mutual Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. [2] Health benefit plans offered/insured by Lovelace Health System, Inc. or its subsidiary, Lovelace Insurance Company. [3] Presbyterian Health Plan, Inc. and Presbyterian Insurance Company, Inc. [4] United Healthcare Insurance Company

	Last Name	First Name	Date of Birth	Male/Female	Height	Weight
Employee				Female		
Spouse				Female		
Child				Female		
Child				Female		
Child				Female		
Child				Female		
Child				Female		

Home Phone: _____ - _____ Work Phone: _____ - _____ Cell: _____ - _____ Home Zip Code: _____

Directions: Please check a Yes or No for each question. If any box is checked "Yes," circle the condition (e.g. stroke) and give details below in the "Details of Medical History" section. **For additional space you may use the lower portion on page 2 of this form.** Please indicate if you or any dependents listed above have **EVER** had any signs or symptoms, or been told to have, or been treated or diagnosed with a condition for which consultation was or will be sought for any of the conditions listed below:

1.	Heart, Stroke, Circulatory, Vascular Disease, High Blood Pressure, High Cholesterol/Triglycerides	☐ Yes ☐ No
2.	Cancer, Tumors, Cysts, Leukemia, Lupus or any other Systemic Disease Type/Location (if applicable) _____	☐ Yes ☐ No
3.	Multiple Sclerosis, Cerebral Palsy, Paralysis, Bone/Joint/Back or Muscle Disorders, Gout, Arthritis, Rheumatoid Arthritis – joint(s) affected: _____	☐ Yes ☐ No
4.	Allergies, Asthma, Emphysema, Respiratory or Lung Disorders, Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes ☐ No
5.	Eye Disorder, Cataracts, Ear, Nose, Throat, Sinus, Tonsil, Adenoid	☐ Yes ☐ No
6.	Diabetes (**specify type** ___ , **HBA1C reading** ___), Insulin Pump, Pancreas, Thyroid, Growth Disorders or Endocrine Disorder	☐ Yes ☐ No
7.	AIDS, HIV, Sexually Transmitted Diseases, Immune System Disorders or Blood Disorders	☐ Yes ☐ No
8.	Hepatitis (**specify type** ____), Cirrhosis, Liver Disorder, Digestive System Disorder, Colon Disorder, Hernia, Gallbladder, Crohn's Disease, GERD, Colitis	☐ Yes ☐ No
9.	Kidney, End Stage Renal Disease, Bladder, Prostate, Reproductive Organs Disorder, Hysterectomy, or Seeking Treatment for Infertility	☐ Yes ☐ No
10.	Migraines, Brain/Nervous System, Brain/Head Trauma, Seizure Disorders, Mental/Emotional Disorders, Depression, Suicide Attempt(s), Alcohol/Drug/Substance Abuse or Dependency. If Epileptic, date of last seizure:___ /___ /___	☐ Yes ☐ No
11.	Organ, Tissue or Bone Marrow Transplant (within your lifetime)	☐ Yes ☐ No
12.	Are you, your spouse, or any dependents to be covered currently pregnant? ☐ Yes ☐ No Due date: ___/___/___ Expecting multiple fetuses? ☐ Yes ☐ No Were previous pregnancies preterm, complicated or high risk? ☐ Yes ☐ No	☐ Yes ☐ No
13.	Fractures, Bone(s) Involved: Surgery Involved ? ☐ Yes ☐ No Date(s) of treatment: _____	☐ Yes ☐ No
14.	Is any person to be covered currently taking any prescription medication(s)? **If "yes" provide details below in the "Details of Medications" section.**	☐ Yes ☐ No
15.	Have you or any of your dependents to be covered been hospitalized, had surgery or been treated at a facility in the past 12 months?	☐ Yes ☐ No
16.	Is there any condition not previously listed that has been a medical concern?	☐ Yes ☐ No
17.	Is there any medical treatment or procedure that has been advised, but not yet done?	☐ Yes ☐ No
18.	Have you or any of your dependents to be covered used cigarettes or other tobacco products in the past 24 months? If yes, specify member(s): _____	☐ Yes ☐ No

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Employer Group Name: _____

Employee Name: _____

DETAILS OF MEDICAL HISTORY (Please be as specific as possible)

Question #	Employee/Dependent Name	Condition/Diagnosis	Disclose Past, Current & Anticipated Treatment	Date of Onset	Treatment Date(s)	Recovery Date

DETAILS OF MEDICATIONS

Employee/Dependent Name	Name of Medication	Condition for which prescribed	Currently Taking?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

By signing below I certify that the answers provided are correct, complete and wholly true to the best of my knowledge and belief. I hereby authorize the release of or use of my protected health information to insurance carriers listed on this form for the purpose of evaluating the medical risk of the employer group of which I am a part. I understand that if I or any of my dependent(s) experience a change in health status after I complete this form or before my coverage becomes effective, it is my responsibility to let my insurance carrier listed at the top of this form know immediately. By completing this form, I understand that I warrant and represent my current and continuing authority to act on behalf of myself and all dependent(s) listed above. Coverage is subject to preexisting condition exclusions, waiting periods, creditable coverage periods, and affiliation periods as allowed by New Mexico law and federal law. Premium, price or charge differentials because of gender or age based on objective, valid, and up-to-date statistical and actuarial data are not prohibited. I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

I hereby authorize any medical provider, facility, pharmacy or pharmacy benefit manager, that possess prescription or medical history about me to furnish such health information to (any of the insurance carriers listed on this form) for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to all of the insurance carriers listed on this form.

Employee Signature: _____ Date: _____

Additional Information/Comments:

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