



*Your Tribal Solution for Complete Self-Funded Benefit Plan Administration*

EMPLOYEE:  
SS/ID#  
PATIENT:  
DATE OF SERVICE:

TO:

The above referenced patient is covered by a medical plan, which has a Pre-Existing condition clause. In order for our office to consider the claims you have submitted for payment, we will need for you to provide us with the information requested below:

TREATMENT DATES AND/OR CONDITIONS SEEN FOR:  
(Please also list all prescribed medications for the Pre-Existing Conditions timeframe listed):

THROUGH

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If you have any questions or need clarification on completion of this form please contact our office at 623-889-7200 or 888-419-6139.

Sincerely,

Tribal Health Partners

Claims Department