

GROUP PRESCREEN

Fax Back to: Physician Partners Health Plan
Representative Name: James Schieferle
Fax No.: (479) 444-6031
Phone: (888) 877-PPHP or (479) 444-PPHP

Please complete this Pre-Screen Worksheet and fax it to the number shown above. **Please also provide a current employee census (including name, date of birth, gender, and coverage type desired).** PPHP will then review the information supplied and will fax back our proposed health plan information.

Group Underwriting Pre-Screen Worksheet

Group Information

Group Name:	State, City, and ZIP:	
Nature of Business:	Phone #:	Multiple Locations: <input type="checkbox"/> Yes <input type="checkbox"/> No
List multiple locations and number of employees at each site:		

Plan Information

Plan Type Desired (i.e., PPO 80/60):	Deductible:	Drug Card?:
Current Health Carrier:		Total Premium:
Current Plan Design: HMO POS PPO Traditional		
Total Number of Employees in Group:		
Total Number of Employees Applying for Coverage:		Renewal Date:
Total Number of COBRA Participants:	Employer Contribution:(EE)	% (Dep) %

Health Conditions (Please use another sheet if necessary)

Employee, Spouse, or Child Name	Age/ Sex	Diagnosis/Medical Condition	Date of Onset	Describe Treatment and List Medications Being Taken	Recovery Date or Ongoing Condition

Proposed Underwriting Action

Best Case:	Medical/Prescription Load:	Industry Load:
Underwriter:		Date:

Disclaimer: This is an estimate based on the information supplied. This pre-screen is not a guarantee of coverage and is not intended to replace the medical underwriting process. Any census change and medical information not disclosed may alter this pre-screen. **Please include a copy of this pre-screen with the case submission.**