University of Washington Student Health Insurance Plan

Welfare & Pension Administration Service, Inc.
P. O. Box 34600 • Seattle, Washington 98124-1600
Claims Dept. (206) 374-9439 or (866) 535-8503 • Fax (206) 441-9110

Pre-Existing Condition Form

Name (first name, middle initial, last name): ____

Address (street address, city, state and zip code): ____

Student ID Number: ____

'IMMEDIATE ACTION IS REQUIRED'

Section 1:

Your medical coverage contains a 3 month waiting period for services relating to a pre-existing condition.

A pre-existing condition is defined as any illness or accidental injury for which any one of the following events occurred during the 3 month period prior to your effective date:

- Treatment or consultation was recommended for or received by you.
- Medication was taken by you.

Consequently, we must ask that you complete this form and return it to us as soon as possible. Future claims that may be related to a pre-existing condition will **not be processed** until this form is received.

Section 2:

I have **NOT** been seen by a medical provider within 3 months prior to my eligibility. If you have selected this option, please complete Section 3 and return this form to the above address.

Listed below are the names of all physicians, clinics and hospitals where I received treatment within the 3 months prior to my eligibility:

Doctor/Facility Name	Address	Condition Treated

(Please use the back of this form to list additional medical providers.)

I have **NOT** taken any medication within the 3 months prior to my eligibility.

I have taken the following medication within the 3 months prior to my eligibility:

Medication	**Condition**

(Use the back of this form to list additional medications.)

If you were treated under a **DIFFERENT NAME(S)** during the 3 month period preceding the effective date of your eligibility, please list those names:

____

____

____

Section 3 (Authorization and Signature):
I authorize any doctor, clinic, hospital, or pharmacy to furnish copies of medical records and/or reports to the administration office for the purpose of establishing a pre-existing condition.

____
(Name) (Please print)

____
(Signature) (Parent or guardian if patient a minor)

Date____________________

If you have been covered under another insurance plan prior to the effective date of your present plan, please submit a copy of your HIPAA certificate or documentation of coverage.

If you have any questions regarding this form, please contact WPAS at 206-374-9439 or by email at studentinsurance@wpas-inc.com.

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