Anthem
Individual Underwriting Department
700 Broadway, UW0989
Denver, CO 80273
Fax: 303-764-7393

Medical Report of _____

Applicant Name: _____
ID No: _____
Return within 10 days

MEDICAL HISTORY

This form must be completed in its entirety.

Date of Exam:_____

Please check any of the following as they apply and provide dates, hospitalization, and other pertinent details in the space provided below.

☐ Heart Disease ☐ Seizure Disorder ☐ Mental Illness ☐ Pulmonary Disease ☐ Alcohol Abuse

☐ Counseling ☐ Cancer ☐ Drug Abuse ☐ Neurological Disorder

☐ Tuberculosis ☐ Diabetes Mellitus ☐ HIV

☐ Participation in a drug or alcohol rehabilitation program

☐ Other injuries, surgeries or illnesses

Explanation:_____

_____

_____

Does this patient have any future surgery or hospitalization planned? _____ If so, please explain:_____

_____

_____

Is the patient currently on medication?_____ If yes, indicate name, dosage and reason for medication _____

_____

LABORATORY

List the following laboratory results or attach a copy of the lab report(s);

Cholesterol Date:_____ Results: TC_____ HDL_____ LDL_____

Triglycerides Date:_____ Results:_____

Blood sugar:_____

Hematocrit or
Hemoglobin Only Date:_____ Results:_____

PHYSICAL EXAMINATION

Height:_____ Weight:_____ Pulse:_____ Respiration:_____ BP:_____

Please indicate (+) if abnormal or (-) if normal as they apply and provide details in space provided.

HEENT_____ Hearing_____ Abdomen_____ Neurological_____ Heart_____

Sight_____ Skin_____ GU_____ Lungs_____ OB/GYN_____

Explanation of any abnormal findings:_____

_____

Name of Attending Physician (Please Print)	Degree/Licensure	Telephone
Street Address	City State	Zip Code
Signature	Anthem Provider Number	Date

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