



Asthma Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
Attn: Underwriting Department
P. O. Box 13047
Roanoke, VA 24030
Customer Svc. Phone: 1-800-718-8831
Fax: 1-800-327-9255

Date: _____

Return by: _____

Underwriting Specialist: _____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information regarding the health status of _____. (You may use additional paper if necessary. All additional sheets must be signed and dated by the applicant). PLEASE INITIAL AND DATE ANY ALTERATIONS.

1. Physician who supervises the asthmatic/Reactive Airway Disease (RAD) condition:
Name _____ Address _____ Phone # _____

2. Date asthma/RAD diagnosed: ____ / ____ / ____
Type of asthma: Extrinsic (allergic) Chronic Intrinsic (late onset) Bronchial
 Exercise induced Status Asthmaticus
 Other - please explain: _____

3. Has this person experienced acute symptoms (attack) requiring treatment in an emergency room or inpatient hospital within the past 12 months? Yes No
If yes, please provide date(s): ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____

4. Date(s) of visits to any physician for treatment or management of asthma within the past 12 months:

Date of Visit (mm/dd/yyyy)	Reason for Visit (please check all that apply):
	<input type="checkbox"/> Prescription Refill <input type="checkbox"/> Prescription change <input type="checkbox"/> Treatment (nebulizer, injection) <input type="checkbox"/> Check-up, no treatment or medication change <input type="checkbox"/> Other (please explain) _____
	<input type="checkbox"/> Prescription Refill <input type="checkbox"/> Prescription change <input type="checkbox"/> Treatment (nebulizer, injection) <input type="checkbox"/> Check-up, no treatment or medication change <input type="checkbox"/> Other (please explain) _____
	<input type="checkbox"/> Prescription Refill <input type="checkbox"/> Prescription change <input type="checkbox"/> Treatment (nebulizer, injection) <input type="checkbox"/> Check-up, no treatment or medication change <input type="checkbox"/> Other (please explain) _____

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An independent licensee of the Blue Cross and Blue Shield Association.

5. Has this person taken any medications (including inhalers) for asthma within the past 12 months?

Yes No **If yes, please complete the chart below:**

Name of Medication	Frequency of Use (check one)		Date of Last Use
	Daily	As Needed	

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

Signature of Applicant or Legal Representative

Date ____/____/____
mo. / day / year

Signature of Spouse or Other Adult to be covered
(if applying for coverage)

Date ____/____/____
mo. / day / year