



# Fracture 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.

- Name and address of physician who is treating or has treated the fracture:  
Name \_\_\_\_\_ Address \_\_\_\_\_
- Date of fracture: \_\_\_\_/\_\_\_\_/\_\_\_\_ Body part(s) involved: \_\_\_\_\_  
Type of fracture:  Open (ex: fragments of bone protruding through skin)  Closed
- Cause of fracture:  Accident  Osteoporosis: \_\_\_\_\_  
 Other medical condition (Please explain: \_\_\_\_\_)
- Does this person currently have a cast for this fracture?  Yes  No
- Was surgery required for this fracture?  Yes  No **If yes**, was internal fixation or retained hardware required (i.e., pins, wires, screws or plates, etc.)?  Yes  No  
**If yes**, what type of device was used? \_\_\_\_\_  
Quantity of each device used: \_\_\_\_\_ Are any device(s) still present?  Yes  No
- Has the fracture healed completely?  Yes  No **If yes**, give date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**If no**, please explain \_\_\_\_\_
- Is this person currently undergoing physical therapy?  Yes  No
- Is this person currently taking any medication related to this condition?  Yes  No  
**If yes**, give name of medication \_\_\_\_\_  
Reason taking: \_\_\_\_\_
- Is any future treatment or surgery planned or advised for this fracture?  Yes  No **If yes**, please explain \_\_\_\_\_

## 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

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