# Prescreening Questionnaire Information and Instructions

## What is a Prescreening Questionnaire?

Colorado Insurance Regulation 4-2-36 requires all health insurance carriers issuing individual health benefit plans to present a universal prescreening questionnaire to all applicants requesting coverage for January 1, 2012 or later effective dates. The questionnaire is short and simple, and asks specific health history questions that require "Yes" or "No" answers. The purpose of the questionnaire is to help applicants quickly determine if they have a condition that makes them eligible for CoverColorado (and ineligible for commercial coverage). It will allow the applicant to avoid completing a long form carrier application only to be declined and directed to CoverColorado.

**Applicants under 19 years of age** who are applying for a **child-only** policy are **not** required to complete or submit the Prescreening Questionnaire. Per state and federal law, child-only policies are guaranteed issue. This means that the Prescreening Questionnaire should not be used as part of the process to enroll them.

## How is the Prescreening Questionnaire completed?

All questions on the Prescreening Questionnaire must be checked either "Yes" or "No". The primary applicant, spouse/domestic partner, and any applicant age19 years or older must sign and date the questionnaire. Questionnaires that are incomplete and/or unsigned will be returned.

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## *Does a Prescreening Questionnaire have to be submitted?*

Although the regulation requires that all insurance carriers present the questionnaire, not every applicant has to actually submit the form.

### Based on the Prescreening Questionnaire:

**If neither you, nor any family member age 19 or older applying with you, checks "Yes" to any condition:**

- **"No" to all conditions:** Neither you nor your family members are required to submit the prescreening questionnaire to Anthem. You can complete the full-length Anthem Individual Enrollment Application and submit it to Anthem as usual.

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## *However, if the applicant answers "Yes" to any condition on the prescreening Questionnaire:*

**If the applicant, or any family member age 19 or older applying with them, checks "Yes" to any condition:**

- **"Yes" to any condition:** you and your family members should not complete and submit the **full-length** Anthem Individual Enrollment application. Instead, you should complete and submit only your completed Prescreening Questionnaire to Anthem either by:

  FAX: to our toll-free #: 800-327-9255
  Or
  Mail: P.O. Box 9041, Oxnard CA 93031

  A decision will be made to issue coverage, ask for additional information, or deny coverage. If the applicant receives a denial from a carrier based on their answers to this form, that denial may serve as your client's CoverColorado medical eligibility form.

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**CO-PRESCRN-QST (1/12)**

# Prescreening Questionnaire

**DO NOT COMPLETE THIS QUESTIONNAIRE IF YOU ARE APPLYING FOR A CHILD-ONLY POLICY.**

| *APPLICANT INFORMATION* | | | | | | | |
|---|---|---|---|---|---|---|---|
| Last Name: | | First Name: | | | | Middle Initial: | |
| Current address: | | | | | | | |
| City: | | State: | | ZIP Code: | | County: | |
| Phone: | | Email Address: | | | | | |
| ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Common Law Marriage | | | | | | | |
| *CARRIER RESPONSES SHOULD BE EMAILED OR FAXED TO:* | | | | | | | |
| *INFORMATION FOR EACH FAMILY MEMBER INTERESTED IN COVERAGE* | | | | | | | |
| **Spouse Information:** | | | | | | | |
| Last Name: | | First Name: | | | | Middle Initial: | |
| **Dependent Information:** Please complete for dependents from age 19 up to age 26. | | | | | | | |
| Last Name: | | First Name: | | | | Middle Initial: | |
| Last Name: | | First Name: | | | | Middle Initial: | |
| Last Name: | | First Name: | | | | Middle Initial: | |
| Last Name: | | First Name: | | | | Middle Initial: | |
| Last Name: | | First Name: | | | | Middle Initial: | |
| Last Name: | | First Name: | | | | Middle Initial: | |

## PRESCREENING QUESTIONS: INDIVIDUAL HEALTH BENEFIT PLANs

**Children under 19 years of age cannot be denied coverage based on a pre-existing condition. If a private health insurance carrier denies you or a family member over the age of 19 coverage based on this form, YOU MAY STILL BE ELIGIBLE FOR COVERAGE WITH COVERCOLORADO and the denial may serve as a denial for purposes of eligibility for coverage through CoverColorado.**

**Has any applicant (which includes the individual completing form, spouse and dependents) ever been diagnosed with any of the following conditions?**

| Condition/Disease/Disorder: | Yes: | No: | Condition/Disease/Disorder: | Yes: | No: |
|---|---|---|---|---|---|
| **AIDS/HIV+** | | | **Malignant Tumor, last 4 years** | | |
| **Alzheimer's Disease** | | | **Multiple or Disseminated Sclerosis** | | |
| **Bipolar Disorder** | | | **Muscular Dystrophy** | | |
| **Cirrhosis of the Liver** | | | **Myasthenia Gravis** | | |
| **Cystic Fibrosis** | | | **Paraplegia or Quadriplegia** | | |
| **Hemophilia** | | | **Parkinson's Disease** | | |
| **Hepatitis, Chronic** | | | **Primary Polycythemia** | | |
| **Hodgkin's Disease** | | | **Schizoaffective Disorder** | | |
| **Huntington's Disease** | | | **Schizophrenia** | | |
| **Lou Gehrig's Disease** | | | **Stroke** | | |
| **Lupus Erythematosus Disseminate** | | | | | |

If you or any family member age 19 or older checked "Yes", please clearly indicate which family member checked yes for which condition:

_____

_____

_____

### Determining Your Coverage Options: PLEASE READ CAREFULLY

**If you or any family member age 19 or older checked "Yes" to any condition on the above list:** Please DO NOT proceed with a full-length application for any private health insurance carrier. Please submit this prescreening questionnaire to the insurance carrier of your choice and that insurance carrier will decide to issue coverage, ask you for additional information, or decide to deny coverage. If you receive a denial from a carrier based on your answers to this form, that denial may serve as your CoverColorado medical eligibility form. If you have medical documentation of the condition marked "Yes" on the list, you may also submit to CoverColorado a letter, on your doctor's letterhead, or a prescription form from your doctor reflecting your doctor's name, address, and phone number for purposes of eligibility in CoverColorado. The letter or prescription form must state the applicant's name and exact diagnosis, and must be signed and dated by your doctor and must accompany your CoverColorado application. The letter or prescription form will serve as your proof of medical eligibility, so a denial letter from a private health insurance carrier will not be necessary. Other eligibility requirements for CoverColorado may apply.

**If neither you nor anyone in your family checked "Yes" to any condition on the list above:** You should proceed directly to a full-length application for any private health insurance carrier with which you may want coverage and submit ONLY the full-length application. Please DO NOT submit this Prescreening Questionnaire.

| Applicant Signature: | | Date: | |
|---|---|---|---|
| Spouse Signature: | | Date: | |
| Dependent Signature: | | Date: | |
| Dependent Signature: | | Date: | |
| Dependent Signature: | | Date: | |
| Dependent Signature: | | Date: | |

| **Contact Information for CoverColorado:** | | | |
|---|---|---|---|
| The individuals with medical conditions on the list above are medically eligible for healthcare coverage through CoverColorado. If you want additional information on CoverColorado please contact an enrollment specialist at the CoverColorado Administration Office at 303-863-1960 or 1-866-787-9129 (8 am – 5 pm MST, M-F), or at: CoverColorado, 425 South Cherry Street, Suite 160, Glendale, CO 80246, or website www.covercolorado.org. | | | |
| Producer Name (if appropriate) | | Date: | |
| Agency Name: | | | |
| Telephone: | | Fax: | |

**Health Insurance Carrier Response:**
**(Completed by the health insurance carrier for those applicants submitting the Prescreening Questionnaire)**

☐ Prescreening Questionnaire Accepted

**Approval for health care coverage is not guaranteed and is based on medical history and health status.** You will be contacted with a full-length insurance application packet. Please do not cancel other current health insurance coverage until written notification is received indicating that your full-length application has been approved.

Name of Accepted Applicant: _____

Name of Accepted Spouse: _____

Name of Accepted Dependent: _____

Name of Accepted Dependent: _____

Name of Accepted Dependent: _____

Name of Accepted Dependent: _____

☐ Prescreening Questionnaire Denied

Name of Denied Applicant: _____

Reason for Denial: _____

Name of Denied Applicant: _____

Reason for Denial: _____

Name of Denied Applicant: _____

Reason for Denial: _____

| Carrier Name: | | Phone Number: | |
|---|---|---|---|
| Carrier Signature: | | Date: | |