

This form letter is designed to assist Integra BMS in accurately processing your claims under the group health plan. Please fully complete all applicable sections and mail this form back to Integra BMS at the address listed below.

Group (Employer) Name:	
Employee Name:	
Employee ID:	
Patient Name:	

Prior Creditable Coverage Section

	Question	Yes or No <i>(circle one and follow directions)</i>	
1	Was the Patient listed above covered under another health plan or plans (through a previous employer, etc.) within 63 days immediately prior to the Employee listed above becoming hired as a full time employee at the Group listed above?	Yes go to question #2	No skip to medical information section
2	Does the patient listed above have a Certificate of Prior Creditable Coverage , which would have been provided by the previous plan or plans whenever the Patient listed above terminated from the previous plan or plans?	Yes go to question #3	No go to #4
3	Does the Certificate of Prior Creditable Coverage indicate at least one year of continuous coverage for the patient listed above?	Yes Forward Certificate(s) to Integra BMS and skip Medical info section.	No Forward Certificate(s) to Integra BMS & also complete Medical information section.
4	Immediately contact your previous employer(s) or insurance carrier(s) and request that they send to you a Certificate of Prior Creditable Coverage for the above patient. They are required by law to send another Certificate to you within a reasonable timeframe. Once you receive this Certificate, please forward to Integra BMS.		

Medical Information Section

Please provide a listing of all medications taken and all of the physicians and/or hospitals who have treated the above Patient from 6 months prior of the Employee becoming hired full-time at the Group listed above, until today's date. Please use additional paper if necessary to include all medications taken and physicians or hospitals which rendered care or treatment.

Physician/hospital name, or name of Rx drug	Indicate the physician or hospital address, or indicate the duration and dosage of the prescription drug.	Physician or hospital phone number
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Employee Certification and Signature

I hereby certify that all information on this claim is accurate and that no information has been omitted.

Employee Signature	Date
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Please submit all completed forms to Integra BMS at:

Integra BMS
Attn: Eligibility Department
P.O. Box 1178
Matthews, NC 28106