Administered by Seven Corners
P.O. Box 3724
Carmel, IN 46082-3724
Toll Free (800) 461-0430

REQUEST FOR INFORMATION

Date: _____

Dear ASPE Member:

Please give this form to your healthcare provider with your identification card.

Provider Name: _____ Patient Name: _____

Provider Address: _____ Certificate #: _____

City/State/Zip: _____

Dear Healthcare Provider:

Please provide the following medical information. Receiving this information will expedite claim processing and payment. Thank you.

1. On what date did the patient first consult you with symptoms related to this condition? _____
2. On what date was this condition originally diagnosed?
   Date: _____ Diagnosis Code: _____ Date: _____ Diagnosis Code: _____
3. If the patient consulted another physician(s) prior to consulting you, please indicate the name and address of the physician(s):
   Name: _____
   Address: _____
   City/State/Zip: _____
4. Has patient ever had the same or similar condition? Yes ◯ No ◯
5. If YES, when did the condition first occur?_____
   Describe circumstances_____
6. Was the patient taking prescription drugs for this condition before consulting you for treatment?
   Yes ◯ No ◯
7. If yes, please specify medication: _____

I certify the above information is true to the best of my knowledge.

Signature: _____ Date: _____ Tax ID#: _____

Please mail to:

USDOS
Attn: Claims
P.O. Box 3724
Carmel, IN 46082-3724