

Mailing Address:
175 Scott Swamp Road
PO Box 4058
Farmington, CT 06034-9863
Fax: (860) 674-2862

Supplement to ConnectiCare® SOLO Application
GASTROINTESTINAL QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN: _____.

Name of person related to condition: _____.

1. Please check off all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Gastroesophageal Reflux (GERD) | <input type="checkbox"/> Esophageal Spasm | <input type="checkbox"/> Ulcer-Type: _____. |
| <input type="checkbox"/> Esophageal Stricture/Spasm | <input type="checkbox"/> Reflux Esophagitis | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Difficult swallowing (Dysphagia) | <input type="checkbox"/> IBS | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Spastic Colon | <input type="checkbox"/> Celiac Sprue | <input type="checkbox"/> Other: _____. |

2. Date of diagnosis? _____. Date of last symptom? _____. Please indicate what symptoms you experienced (heartburn, palpitations, chest pains, etc.): _____.

3. What was the cause of this condition (if any)? _____.

4. How many occurrences have you had of this condition in the last 2 years? _____. When was the date of your last occurrence? _____.

5. Have you ever been hospitalized or gone to the emergency room for this condition or any other related condition? Yes or No: _____. If yes, how many times, when, and the location? _____.

6. Was medication prescribed? Yes or No: _____. If yes, what is the name of the medication, dosage and frequency with which you take it or have taken it? _____.

7. Were any tests taken related to this condition (x-rays, Upper GI, ultrasound, colonoscopy, sigmoidoscopy, barium enema, biopsy, endoscopy, etc.)? Yes or No: _____. If yes, please indicate the type of test(s): _____. When? _____. Results (benign or malignant): _____.

8. Have you had surgery for this or any other related condition, or do you plan to have surgery in the future? Yes or No: _____. If yes, when? _____.

9. Have you made dietary changes? Yes or No: _____.

10. How has this condition impacted your activities of daily living? _____.

Please provide the name and address of the treating physician for the condition(s) above: _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): _____.

Today's Date: _____.