Anthem

# EAR / OTITIS QUESTIONNAIRE
## (Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Give diagnosis of ear disorder: _____
2. Date diagnosed or date of first symptoms: _____
3. How many episodes in the past 2 years? _____
   Frequency of episodes? _____
4. Give details including dates of past and current treatment: _____
   _____
   _____
5. Any prescription medications taken for this condition? ___ Yes ___ No

   **Name of Medication:** **Dosage** **Frequency (ie, daily, as needed)**

   _____
   _____
   _____
6. Give name and address of treating physician: _____
   _____
7. Date last seen for this condition? _____
8. Ever had or been advised to have surgery? ___ Yes ___ No
   If yes, give details: _____
   _____
   _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge.
I understand that the insurer will rely on these statements when determining eligibility.

_____ _____

Signature of person treated (or parent/guardian if under 18) Date

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