



Request for Reconsideration of Rate

Member Name: _____ ID Number: _____

I wish to submit the following request for the TRH Underwriting Department to reconsider my rate for coverage.

Please read carefully and note the following:

- Claims experience from any previous TRH health plan or health coverage with BlueCross BlueShield of Tennessee may be used in the reconsideration process. If the factors in your original rating decision are resolved in your favor, please know that symptoms, treatments, and/or claims experience for other medical conditions discovered during this review may cause your rate not to be adjusted.
- If you were rated due to medical conditions such as blood pressure, cholesterol, and/or weight, you may need to provide documentation showing at least six (6) month maintenance of within-range, normal test results and/or lowered weight appropriate for your height.
- If you were rated for or have any other medical conditions, you will need to indicate how long you have been treatment-, medication-, and symptom-free of these conditions.
- **If you and/or your spouse are age 40 or older**, we will need current medical records including height, weight and blood pressure readings (within the last 6 months), fasting lipid (cholesterol) panel, fasting glucose (sugar) results, and a list of current medications (within the last 12 months). It will be your responsibility to provide this information.
- This information submitted may result in the TRH Medical Underwriting Department requesting additional medical information. Obtaining this information and any expenses incurred will be your responsibility.

Answer each of the following questions completely and accurately for you, your spouse, and all dependents on this contract. **We will not be able to process this request without the requested information.**

1. Have you, your spouse or any dependent children ever: received medical advice or treatment; been medically diagnosed; or experienced symptoms for any of the conditions below? Check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease or Condition | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ear Infections/Ear tubes |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Brain Injury or Condition | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Depression / Anxiety / ADHD | <input type="checkbox"/> Back / Neck Pain |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Chiropractic Treatment |
| <input type="checkbox"/> Cancer or Skin Cancer | <input type="checkbox"/> Diabetes / Elevated Glucose | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Kidney / Bladder problems | <input type="checkbox"/> Cyst, Tumor, or Polyp |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver Problems or Hepatitis | <input type="checkbox"/> Heartburn, GERD, Reflux |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis/ Joint Pain | <input type="checkbox"/> Alcohol or Drug Use/Abuse |

For any conditions checked above, please list who, when, and what condition: _____

Use the space below to provide any additional past medical history information not indicated above.

2. In the last five (5) years, has anyone on this contract had any type of surgery? If "yes," list who, when, and what type of surgery: _____

3. In the last five (5) years, has anyone on this contract been hospitalized? If "yes," list who, when, and for what reason:

4. In the last five (5) years, has anyone on this contract been advised of an abnormal test result? If "yes," list who, when, and what test: _____

5. List all medications that are currently being taken or have been taken in the last two (2) years for you, your spouse, and all dependent children on this contract:

Name:	Name of Drug:	Illness:	Date Started:	Date Stopped:

6. List a current height and weight for everyone on this contract:

Name:	Height:	Weight:	Date Weighed:

You may also attach pertinent documents including medical records, pharmacy records, and any other information you would like considered during the reconsideration process.

Please send this form along with any documentation to the below address:

TRH Health Plans
 Attention: Underwriting Department
 P.O. Box 313
 Columbia, TN 38402-0313

I understand the information in this request for reconsideration and any information obtained with this authorization will be used by TRH to determine the outcome of this reconsideration. I declare that the foregoing statements provided by me on this request in its entirety are true, correct and complete for myself, my spouse and all dependent children.

Member Signature: _____ Spouse Signature: _____ Date: _____