



Administered by Seven Corners, Inc.
 P.O. Box 2185
 Eagan, MN 55121
 Toll Free: 1-800-461-0430
 Fax: 317-575-6467

Request for Information Form

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:

Seven Corners
Attn: USDOS Claims
 P.O. Box 21185
 Eagan, MN 55121