MONTANA
MEDICAL SHORT FORM

PacificSource HEALTH PLANS

Employer/group name

Employee and Family Members Requesting Coverage

Employee (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth (MM-DD-YY)
Spouse or Domestic Partner (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth
Dependent Child (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth
Dependent Child (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth
Dependent Child (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth
Dependent Child (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth
Dependent Child (First, MI, Last)	Height	Weight	Gender ☐ M ☐ F	Date of Birth

General Health Information

Have you or a dependent listed above experienced the following:

1. **Within the past five years,** admitted to a hospital, emergency room, or other medical facility or had medical expenses of at least $5,000 in any one year? ..... ☐ Yes ☐ No
2. **Within the past five years,** treatment for: cancer/tumor; transplant; heart attack/bypass/angioplasty/ stroke/clotting disorder; Hodgkin's/lymphoma/leukemia; liver disorder/hepatitis? Tested positive or received counseling/treatment for HIV or AIDS? ..... ☐ Yes ☐ No
3. **Within the past five years,** alcohol or drug use; respiratory disorders; back pain; arthritis; Crohn's; diabetes; hypertension; high cholesterol; nervous system disorder; seizures; headaches; mental/nervous disorder; partial or total disability? ..... ☐ Yes ☐ No
4. **Within the past five years,** kidney, bladder or prostate disorder; gynecological disorder; anemia or blood disorder; rectal disorder; thyroid, endocrine, adrenal or lymph enlargement or disorder; ulcer, stomach, or intestinal disorder; bariatric/gastric bypass; fertility treatment? ..... ☐ Yes ☐ No
5. **Currently** taking any prescription medications? If yes, please list below or on a separate sheet. ..... ☐ Yes ☐ No
6. Is anyone listed on this application currently pregnant? ..... ☐ Yes ☐ No

   Due Date: _____ Fetus: ☐ One ☐ Multiple Any complications? ..... ☐ Yes ☐ No

Please provide details for all "Yes" answers. Use separate sheet if necessary.

Question #	Name of Patient	Condition/Treatment/Results	Duration (MM-YY)	
			From	To
			From	To
			From	To
			From	To

By signing or typing your name below, you certify the information provided on this form and any attachments used to complete this form are accurate to the best of your knowledge. If you type your name below, you understand you are electronically signing this document.

Signature (sign or type your legal name)	Date