

IFP probable underwriting decision request

Blue Shield can help you evaluate applicant eligibility for IFP coverage.

1. Complete this form. Probable underwriting decisions require a complete health picture for each person listed on the application. If you need more room to provide details on conditions and/or medications, please attach an additional sheet of paper.
2. Fax the form with any additional pages to Blue Shield Underwriting at **(209) 371-5831**. **Be sure to include your return fax number on the form below** (under "Broker Information").
3. Expect a response by fax within 24 hours of submitting your completed probable action request.

Required information

Applicant initials		No. of applying family members		County of residence	
Shield Saver plans <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 Shield Wise plans <input type="checkbox"/> 2500 <input type="checkbox"/> 3500 <input type="checkbox"/> 4500		Shield Secure plans <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 Shield Secure Plus plans <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000		Blue Shield HMO plans <input type="checkbox"/> Access+ HMO® package <input type="checkbox"/> Access+ Value SM HMO	
				Shield Spectrum PPOSM plans <input type="checkbox"/> PPO 5000* <input type="checkbox"/> PPO 5500	

Medical conditions

Applicant data					Dependent No.1 data				
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Height	Weight	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Height	Weight	Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No
Specific diagnosis			Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No		Specific diagnosis			Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	
Complete details of condition, including current status					Complete details of condition, including current status				
Treatment date(s) Start: _____ End: _____		Recovery date(s) if applicable			Treatment date(s) Start: _____ End: _____		Recovery date(s) if applicable		
Current medications/dosages					Current medications/dosages				

General concerns/questions (Please attach additional pages as needed)

Producer information

Producer name	Producer ID	Phone	Fax	E-mail
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For underwriting use only – underwriting response

<input type="checkbox"/> Possible Tier 1 <input type="checkbox"/> Possible Tier 2 <input type="checkbox"/> Possible Tier 3 <input type="checkbox"/> Possible Tier 4 <input type="checkbox"/> Possible Tier 5 <input type="checkbox"/> Possible Tier 6† <input type="checkbox"/> Possible Maximum Tier <input type="checkbox"/> Decline	Notes	
	Underwriter	Date

This is not a final underwriting decision or acceptance of coverage. Underwriting provides this service as a courtesy to help you understand how Blue Shield might underwrite your client in advance of submitting an application. The probable underwriting decision we provide to you is based on the information you provide in the form, and does not constitute a final decision for coverage. Final decisions for coverage are based only on a signed, complete application.

* Underwritten by Blue Shield of California Life & Health Insurance Company

† Applies to child applicants under age 19. Must be in birthday month or meet the qualifying event criteria.