

D & C Questionnaire

Claims Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

Original Symptoms: _____

Diagnosis: _____

Hospitalization: Outpatient length of stay: _____

 Inpatient length of stay: _____

Follow-ups: How often? _____

 Findings: _____

Any recommendations for further treatment or procedures? Yes or No

Please explain: _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

