

Pre-Existing Condition Letter

This letter must be signed by a Doctor (M.D. or D.O.), Physician Assistant, or Nurse Practitioner who is licensed to practice.

The letter must include the information shown on this sample. In order for the letter to be acceptable, it must be dated within 12 months from the date the Pre-Existing Condition Insurance Plan (PCIP) receives the application.

Health Care Provider's Letterhead

Health Care Provider's or Facility's Name
Address
City, State, Zip
Telephone Number

Today's Date

To: Pre-Existing Condition Insurance Plan

Patient's Name: _____ Patient's Condition: _____
(First & Last Name)

I certify that this patient has or has had in the past, the medical condition, disability, or illness listed above.

I declare that the information provided above is true and correct to the best of my knowledge.

Sincerely,

Health Care Provider's Signature
Health Care Provider's Printed First & Last Name (i.e. person signing the letter)
Health Care Provider Category (i.e. Doctor (M.D. or D.O.), Physician Assistant, or Nurse Practitioner)
License Number