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Supplement to ConnectiCare® SOLO Application
TUMOR/SKIN QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN: _____
Name of person related to condition: _____

Please check all that apply related to your diagnosis:

Actinic Keratosis Basal Cell Carcinoma Squamous Cell Carcinoma
 Skin Tags Tumor or Cyst Eczema
 Acne Psoriasis Melanoma
 Moles Other: _____

1. Was the lesion diagnosed as malignant or benign? (If malignant, provide details: i.e. stage, grade, Clark level (Melanoma), Class (Tumor) or Gleason (Prostate) score.

2. Size of tumor/cyst/skin lesion? _____. Location(s)? _____.
What is the severity of this skin disorder(mild, moderate, severe)? _____
3. Has there been any metastasis or spread to any other location(s)? Yes or No: _____. If yes, please provide details: _____
4. Has there been a recurrence, relapse or multiple episodes of any lesions including warts? Yes or No: _____. If yes, please provide details(how many in the last 12 months, etc.): _____
5. Did you receive medication for the tumor/cyst/skin lesion? Yes or No: _____. If yes, please provide name, dosage, and frequency with which you take it or have taken it: _____
6. Did you receive radiation or chemotherapy for the tumor/cyst/skin lesion? Yes or No: _____. If yes, please provide details and date(s) taken: _____
7. Have you had surgery or been advised to have surgery to remove the tumor/cyst/skin lesion? Yes or No: _____. If surgery done, when? _____. Have you been released from treatment? Yes or No: _____. If yes, when? _____
8. Are further studies or future operations for the tumor/cyst/skin lesions anticipated? Yes or No: _____. If yes, what type and when? _____
9. Are there any other lesions on your body that have not been checked by a physician? Yes or No: _____. Please provide any other pertinent details: _____
10. Please provide the name, address and phone number of treating physician(s): _____

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Person related to condition (or parent/guardian if under 18): _____
Today's Date: _____