CONVENTUS

Authorization to Release Coverage Verification/Claim History

Please complete the information below in its entirety and legibly for prompt processing.

☐ **I am NOT a current insured of Conventus Inter-Insurance Exchange**. If the healthcare provider is no longer a Conventus member-insured, there is a **$30 fee** for each healthcare provider (subject to a maximum $100 fee on a Group Policy). Kindly include a **check or money order <u>made payable to Conventus</u>** which must accompany each request for processing.

☐ **I am currently insured** by Conventus.

Complete to ensure processing of proper individual (all fields required):

Practitioner's full name: _____

Current mailing address: _____

City: _____ State: _____ Zip Code: _____

Current phone #: _____

Policy #: _____ Medical license: _____ Last (4) digit of your Social Security No. ☐☐☐☐

Please send my report to (all fields required):

Company name: _____

Attention to: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax # or email address (if you prefer instead of a mailed copy): _____

I authorize Conventus Inter-Insurance Exchange to release my claim/coverage history to the above entity.

My signature below authorizes the release of the claim history. The authorization expires in 30 days from the date signed unless another date is specified here _____.

_____   _____
Signature of Provider (NO STAMPED SIGNATURES)   Date (Required)

Fax or Mail Completed Form (and payment, if applicable) to: Conventus Inter-Insurance Exchange
900 Route 9 North, Suite 503
Woodbridge, NJ 07095
Conventus@conventusnj.com
Fax: (732) 791-9431   Phone: (877) 444-0484