**Letter of Insurance Verification/Claims History**

Dear :

Please furnish the following requested information to the party noted below:

1. Time period(s) of coverage including date(s) of initial coverage

2. Limits of Liability

3. Retroactive date (if applicable)

4. Confirmation of Tail Coverage/Extended Reporting Period Coverage (if applicable)

5. Five (5) years of claims history including date(s) of occurrence, indemnity payment amount(s), indemnity reserve amount(s) and loss details.

I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter, or insurance agent to furnish any information concerning me or my medical practice that the company may request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of practitioner Date of Completion

Name – Printed or Typed

Please provide this information at your earliest ability to:

Name:

Facility/Practice Name:

Fax:

Email:

Phone:

|  |  |
| --- | --- |
| **Date:** |  |
| **Verifying Entity:** |  |
| **Facility:** |  |
| **Name:** |  |
| **Employment Start Date/Retro/Earliest Date of Coverage:** |  |
| **Termination:** |  |
| **Policy #:** |  |
| **Policy Period:** |  |
| **Consent:** |  |
| **Notes:** |  |